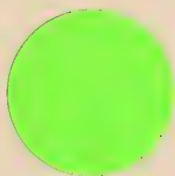


# STATE PROGRAMS of ASSISTANCE for the MEDICALLY INDIGENT



November 1985

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# **STATE PROGRAMS of ASSISTANCE for the MEDICALLY INDIGENT**

**November 1985**

by

**Randolph A. Desonia**

and

**Kathleen M. King**

of the

**Intergovernmental Health Policy Project  
The George Washington University**

## **AUTHOR'S NOTE**

This document is one of a series of publications intended to meet the needs of state and local policymakers. For further description and analysis of the issues raised in this report, please refer to the following publications:

**Access to Care for the Medically Indigent:  
A Resource Document for State and Local Officials**  
The Academy for State and Local Government  
444 North Capitol Street, N.W.  
Washington, D.C. 20001  
202/638-1445  
Price: \$15.00

This publication provides a brief overview of the size and nature of the populations and of health care market and policy trends that are likely to cause increasing problems with access to care for these individuals. An analysis of state laws and judicial decisions provides an overview of national patterns as well as state-by-state information regarding state and local government legal responsibility for financing indigent health care. Policy options are outlined and ten case studies of existing model state and local policies include information on program design, financing mechanisms and populations served, as well as contextual demographic and economic information.

**A Review of State Task Force  
And  
Special Study Recommendations  
To  
Address Health Care for the Indigent**  
Intergovernmental Health Policy Project  
Suite 616  
2100 Pennsylvania Avenue, N.W.  
Washington, D.C. 20037  
(202) 872-1445  
Price: \$10.00 (Prepaid)

This report, prepared with the Center for Policy Research, National Governor's Association, describes the background, analysis, findings, and recommendations of various state level groups formed to address issues related to indigent health care. Summaries of current activities in 21 states are presented and a resource person for each state is identified.



## ACKNOWLEDGMENTS

A report as encompassing as this requires considerable assistance and cooperation from many parties. First and foremost, we thank all the state government workers who took time from their busy schedules to respond to our survey and our followup questions. Without their cooperation the completion of this report would have been impossible.

In compiling the original data on state programs to assist the medically indigent, several sources proved very helpful. While at IHPP John Luehrs amassed state-by-state files on indigent care that were indispensable. Documents that proved useful included: Characteristics of General Assistance Programs, (May 1983) by Urban Systems Research and Engineering Inc; "Coverage of Uncompensated Care under Prospective Hospital Reimbursement Systems" (May 11, 1984), a memorandum by the National Health Law Program; State Options for Addressing Catastrophic Health Expense (April 1983), prepared for the National Center for Health Services Research; and draft copies of Responsibilities to Provide Medical Care for Indigents, by Mike Dowell of the National Health Law Program. Douglas Reese and Pam Stewart of IHPP assisted in organizing and verifying information.

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State Programs of Assistance for the  
Medically Indigent

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## EXECUTIVE SUMMARY

### Background

Assuring access to health care for the medically indigent -- people with little or no public or private health insurance and without resources to pay for essential medical services -- has become one of the most pressing health care issues of the 1980s. In their 1984 legislative sessions, 22 states introduced legislation with the objective of improving the medically indigents' access to health care. Since 1984, 20 states have organized legislative or gubernatorial study commissions with financing health care for the medically indigent as the primary focus or an important secondary concern of medical care cost containment efforts.<sup>1</sup> The primary objective of this report is to identify and document the major state policies and programs designed to improve access to health care for the medically indigent.

Although the provision of funding of health care services for the medically indigent has long been a concern of national, state and local policymakers, recent events have brought it to the forefront. A major catalyst appears to have been the recession of 1981-82 when the nation experienced a slowdown in the growth of the economy and high unemployment levels. The Employee Benefit Research Institute, using the Current Population Survey Statistics of the U.S. Census Bureau, found that about 14 percent of the nonelderly population were without health insurance coverage from any source in 1979. That proportion rose to 15.5 percent in 1982 and 16.5 percent in 1983.<sup>2</sup> The uninsured, especially when unemployed, are at great risk of becoming medically indigent.

Although the nation's unemployment rate has returned from a high of 10.8 percent to the pre-recession level of 7 percent, millions of people are still without jobs. Despite the fact that 1983 marked an upturn in the nation's economy, the Employee Benefit Research Institute noted nearly one million fewer people were covered by employer plans in 1983 than had been covered in 1982.<sup>3</sup> Since 85 percent of those with private sector health coverage obtain it through job related health plans, any unemployment rate above the full employment level will contribute to the number of uninsured and therefore to those at risk of medical indigency.<sup>4</sup>

The recession also gave rise to two other pressures that exacerbated the medical indigency problem: federal and state cutbacks in programs assisting the medically indigent; and private and public efforts to control continually rising health care costs. Governmental



cutbacks and cost containment efforts clearly were taking place before 1981, but both intensified with the advent of the recession.

Since 1975, Medicaid -- the largest governmental health program for the poor -- has become less effective in its ability to cover the medically indigent population. In 1975, 63 percent of the population near or below the poverty line were eligible for Medicaid; in 1983, the number covered fell below 50 percent.<sup>5</sup> This occurred during a period when the number of people in poverty increased. The decline was a result of a combination of federal cutbacks in Medicaid and declining state revenues that forced many states to reduce the scope of their Medicaid programs.

Government spending cuts and increases in the unemployment rate have occurred before and most likely will occur again. When the economy improves -- which it has -- federal and state governments frequently reinstate coverage of benefit and eligibility cuts -- which many have. Still, improvements in the economy and restoration of program cuts have not bumped the issue of health care for the medically indigent from the states' legislative agendas. It is a third factor, public and private sector efforts to control health care costs, that appears to explain why health care for the medically indigent continues to attract policy-makers' attention.

A decade of inflation in medical costs that consistently exceeded the general inflation rate propelled businesses and governments to aggressively search for and adopt policies to control their health care costs. Such cost containment initiatives as Medicare's prospective payment system (based on Diagnosis Related Groups), selective contracting in California and competitive bidding in Arizona under Medicaid, record growth in HMO membership and the proliferation of preferred provider organizations have put enormous pressure on providers to deliver health care in a more cost efficient manner. Under these new conditions, the efficient provider is rewarded with adequate reimbursement that assures continued survival in the competitive market place.

For the most part, the new competitive reimbursement systems do not cover bad debt or charity care, and they preclude the provider from charging higher rates in order to cover bad debt or charity care (commonly referred to as cost-shifting). Thus providers, particularly public hospitals, who continue to serve everyone, regardless of their ability to pay, are at risk of not covering their costs. It is not surprising that many providers have grown increasingly reluctant to provide charity care to the medically indigent. In fact, many of the states that have examined the issue of indigent care were originally studying cost containment proposals.

It is impossible to separate the magnitude of each of the three contributing factors because in large part, each is affected by the

other. For example, the recession gave employers a rationale for instituting major cost-saving changes in their employee benefit plans to cut business expenses. But taken together, the recession (and continued unemployment), governmental program cutbacks and cost containment efforts have focused renewed attention on the long-standing problem of assuring the medically indigent access to necessary health care.

### Who are the Medically Indigent?

The report briefly summarizes the numerous national and state studies that identify and describe the medically indigent population. Although different studies often yield seemingly conflicting results, discrepancies usually arise because the studies adopt different definitions of indigency, draw from different data bases, or were conducted in different years.

Nationally, according to two studies, 15 to 16 percent of people under the age of 65 lack health insurance at any given time (Kasper et al, and Schwartz).<sup>6</sup> This percentage translates into about 35 million people. Another study estimates that an additional 13 percent of the nation's population under age 65 has inadequate health insurance coverage (Farley).<sup>7</sup> That is, the insurance policy fails to cover major health costs and the policyholder is in danger of financial hardship or even ruin in the event of a major illness.

At the state level, however, variations in the estimates of the size of the medically indigent population can be significant. For example, New Mexico and Colorado estimate that 20 percent of their population lack health insurance coverage, while Minnesota puts its level at 8 percent.

Although the specific characteristics of the medically indigent vary by state -- depending on the type of employment common to the particular state (manufacturing, construction, retail, etc.), the comprehensiveness of Medicaid coverage, and the average income of the residents -- the key determinants of medical indigency are unemployment, employment in small or low-wage firms, and income status. One national study estimated that 13 percent of those who lost their jobs during the 1982 recession were left without any insurance coverage (Wilensky).<sup>8</sup> A study in a major metropolitan area found that 38 percent of the unemployed had neither private health insurance nor Medicaid coverage (Berki).<sup>9</sup> And a study by the Urban Institute estimated 25 percent of uninsured adults worked full-time for 40 weeks or more (Schwartz),<sup>10</sup> presumably because they worked for small firms that do not offer health insurance as a fringe benefit.

In examining the health insurance coverage of the poor, one national study estimated that 15 percent of the poor -- people at or

below 125 percent of the poverty level -- were ineligible for Medicaid and lacked private health insurance (Wilensky and Berk).<sup>11</sup> In surveying people with incomes below 150 percent of the federal poverty level, Colorado found that 38 percent did not have private health insurance and were ineligible for Medicare and Medicaid.

Other characteristics of people at risk of being medically indigent are age and place of residence. Depending on the state, the two age groups most frequently identified as having the lowest levels of health insurance coverage are children under the age of 18 and young adults age 18 to 24 (or frequently, 18 to 35). People living in rural areas and those residing in the southern and western regions of the country also have lower health insurance coverage levels (Mulstein).<sup>12</sup>

### State Indigent Care Programs: Findings

It is not widely understood that for years many states -- often in conjunction with local units of government -- have operated programs to assist medically indigent residents. This report is an initial effort to document these programs in order to assist federal, state and local policymakers in developing or modifying their policies affecting health care delivery to that group. The emphasis of this report is on statewide programs; programs supported by local or county governments independent of state efforts are not included due to the lack of data and limited staff resources.

Every state has adopted legislation authorizing various levels of government to provide certain health and medical services for its residents. And in all but three states, either the state or local government is expressly obligated by law to provide at least some health services to some indigent populations (Butler).<sup>13</sup> The report found that as of July 1985, 34 states had state indigent care programs, which are state programs designed to assist the medically indigent and administered or funded wholly or in part by the state government. Programs that rely on federal monies -- Medicaid and the maternal and child health block grant, for example -- were specifically excluded as were local programs that serve only a limited region of the state.

In the 16 states that do not have a state indigent care program, counties and municipalities generally have some legal responsibility for providing medical care to their residents. However, those requirements tend to be rather general and imprecise leading to broad variations in benefit coverage, eligibility standards and program administration. Also, it is rather common that counties supporting a public hospital are not only required to provide care to resident indigents but are often expected to provide care to nonresident indigents. Recent changes in Florida and Texas programs were, in part, caused by this movement of indigents across counties.



Of the 34 states with indigent care programs, IHPP identified 41 programs (five states had more than one program). Although each of the programs is unique, they do have several features that allow comparison including such program components as financing, eligibility standards, administration and benefit coverage. In any indigent care program, the state or the county must assume certain administrative functions: establishing the eligibility standards, deciding which medical services will be reimbursed, and processing providers' claims. Seventeen states administer all components of their indigent care program; in the remaining seventeen, the state and the counties share the administrative responsibilities.

Eighteen states totally funded their indigent care programs, and 15 states financed the programs jointly with local governments, usually counties. The state-local share in those states ranged from 50 percent state and 50 percent county, to 92 percent state and 8 percent county. While most of the funds for these programs are derived from state general revenues, a few states rely on other funding sources. Those counties sharing in the financing of a state indigent care program raise revenue through a sales tax or a property tax. South Carolina's program, to be implemented in 1986, has the most unique means of funding making separate assessments on the counties and on hospital net patient revenues. Two other states -- Florida and West Virginia -- have adopted an assessment on hospital revenue, but in both states the revenue is used as the state match for recent expansions in their Medicaid programs.

Frequently, states with shared responsibility delegate responsibility for determining eligibility to the counties, and assume responsibility for the other administrative duties themselves. In twenty six states, the state government is responsible for establishing eligibility standards for the indigent care programs while in the other eight, the counties are totally or partially responsible for establishing eligibility standards. The advantage of the state setting the eligibility standards is that the standards will more likely be uniform across county lines.

Twenty-two states have indigent care programs associated with state or county general assistance programs. General assistance programs (also called general relief, home relief, and poor relief) provide continuing or emergency income assistance and serve as the ultimate "safety net" for poor individuals and families ineligible for federally-supported assistance programs like AFDC and SSI. In most instances, the general assistance program has a medical component so that all those who qualify for aid are entitled to receive some medical benefits.

A common variation of the state indigent care program is the state created optional program providing state assistance for participating counties or towns. In these states, the local unit of government is

legally responsible for providing care to their medically indigent residents. An optional state program offers to assist the local units of government in meeting their obligation, usually through administrative or financial assistance. If the local unit of government elects not to participate, it must then administer its own program.

Eight states offer optional indigent care programs, four of which are tied to their general assistance program. New Jersey's General Assistance-State Medical Match program, for example, provides a 75 percent state match for medical services provided to any indigent meeting state eligibility criteria. Nonparticipating municipalities must fund such programs totally with their own dollars.

Sixteen of the 34 states with indigent care programs cover both hospital and ambulatory services similar to those mandated services provided under Medicaid. By law, Medicaid must provide inpatient and outpatient hospital services, physician services, lab and X-ray procedures, rural health clinics, home health services, and skilled nursing facility services. Frequently, however, states put greater restrictions on services provided under their indigent care programs. For example, Oregon limits inpatient hospitalization to 18 days per year for Medicaid recipients and 12 days per year for general assistance recipients. Maryland's general assistance program requires a \$0.50 copayment on prescription drugs but makes no such demand under its Medicaid program.

Another nine states have more limited coverage of inpatient and hospital services, and physician services. Of the remaining nine states, Vermont and Massachusetts cover ambulatory services only, and South Carolina, Louisiana, Mississippi, and Oklahoma limit coverage to hospital services. Maine, Wisconsin and Montana assist the counties in financing indigent care but allow counties to decide which services to reimburse. The state programs rarely cover long term care. In those that do cover such services, it usually accounts for only a small percentage of program expenditures.

During fiscal year 1983, the states and counties spent more than \$2.3 billion on the 41 programs. This is in addition to the states' share of \$16 billion for the Medicaid program in FY 1983. The \$2.3 billion is undoubtedly low because not all county contributions to the programs were available. Nor does the \$2.3 billion take into account state spending on programs for specific diseases or populations such as for renal dialysis, sickle cell anemia and hemophilia or pharmaceutical assistance to the elderly. Finally, it does not include the funds counties give directly to hospitals to help them offset the cost of uncompensated care.



### Other State Policies and Programs

Financing and administering statewide indigent care programs is certainly the most significant option the states have chosen to assist the medically indigent, although other alternatives do exist. For example, several states have health programs designed to reach a small target population or supplement existing federal, state or locally funded medical service programs. Since the range of services and numbers of people they serve can be quite limited, these programs should be viewed as supplementing rather than substituting for state indigent care programs.

Many programs attempt to provide some assistance for people suffering from specific diseases or afflictions such as sickle cell anemia, cancer, hemophilia, blindness, and tuberculosis. Another approach is to provide assistance to a specific population. Five states fund pharmaceutical assistance programs for low income aged or disabled, for instance.

Another alternative involves the application of the state's authority to expand the availability and comprehensiveness of insurance coverage through the private health insurance market place. As of April 1985, nineteen states had enacted laws requiring insurers to permit those whose health insurance policies have been terminated, usually as the result of lay-offs, to continue their policies for anywhere from 30 days to one year. Policyholders pay the entire premium but benefit from group rates rather than having to pay more expensive individual rates. Thirty-one states have also enacted conversion statutes requiring insurers to permit those whose policies have been terminated to convert from group to individual policies.

Nine states (Connecticut, Florida, Indiana, Minnesota, Montana, Nebraska, North Dakota, Rhode Island and Wisconsin) have established comprehensive health insurance associations, more frequently called "risk pools." These pools are designed to make available a health benefit plan to individuals unable to obtain coverage, even though they can afford reasonable premiums, because of their poor health status. The premiums, set under these state programs for the so-called "un-insurables" tend to be expensive, ranging from 125 to 150 percent of those charged to standard-risk policyholders. So far, no state has been willing to subsidize the cost of premiums for low-income people.

Alaska and Rhode Island operate catastrophic health insurance programs designed to mitigate the financial effects of lengthy, costly illnesses. (Maine operated a program for several years, but it was amended in 1985 to cover only ambulatory care. Catastrophic inpatient hospital costs are covered under the state rate setting program.) These state catastrophic programs are designed to be the payer of last resort. That is, all third party insurance coverage, if any, must be fully exhausted before the state's contribution begins, and the person

is liable for sizable deductibles and copayments. The state program then assumes responsibility for a portion of the remaining expenses. Setting the deductible high -- that is, requiring the applicant to spend a certain amount before becoming eligible -- discourages participation by people who are poor. In Rhode Island, for example, the minimum deductible is the greater of \$1,035 or 10 percent of income for those with comprehensive health insurance. Those without health insurance are required to pay the greater of \$10,350 or 50 percent of allowable income. Both programs have substantially increased their deductibles in the past few years to target benefits to people suffering catastrophic illnesses and to control costs.

The final options discussed involve the use of the states' regulatory authority to extract some level of charity care from institutional providers or to ensure that all third party payers share evenly in the burden of financing care for the medically indigent. Four states plus the District of Columbia have adopted policies that, under certain circumstances, tie certificate of need (CON) approval to the applicant's commitment to providing charity care. Georgia issued a regulation in 1984 that requires parties purchasing or leasing a public hospital to provide an amount of charity care equal to 3 percent of the hospital gross revenue for the sale or lease to be approved. South Carolina has adopted a policy that requires all health care facilities to include an indigent care plan in their CON applications.

Four states -- Maryland, Massachusetts, New Jersey, and New York -- have implemented so-called all-payer hospital rate setting programs. (During the preparation of this report, however, Massachusetts' and New York's Medicare waivers were terminated and not renewed.) Each system operates differently, but all include some provision for uncompensated care. For example, New Jersey's system is based on DRGs. There, hospitals' payments are increased by an uncompensated care factor that reflects its ratio of uncompensated care to gross revenues. Massachusetts -- which has a state indigent care program that covers only services delivered outside of a hospital setting -- requires hospitals to provide charity care in order to receive payment for uncompensated care. Wisconsin and Washington have rate setting mechanisms that do not include a Medicare waiver. Three other states -- Connecticut, Maine, and West Virginia -- are in the process of implementing multiple or all-payer hospital rate setting programs.

In 1984, 14 states had organized gubernatorial or legislative study commissions to develop policy recommendations. By August 1985, an additional 8 states had adopted legislation requiring the state to study the issue and four of the 14 states of 1984 had adopted legislation requiring further study of the issue.<sup>14</sup> With 15 to 16 percent of the nation's population uninsured, and with the public and private sectors continuing to implement cost containment strategies, the search for solutions to ensure greater access to health care services for indigents will undoubtedly remain one of the major priorities of federal, state and local policy makers over the next few years.

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## CHAPTER I

### AN OVERVIEW OF THE MEDICALLY INDIGENT PROBLEM

Assuring access to medical care for the "medically indigent" -- those with little or no public or private insurance and without resources to pay for essential medical services -- has become one of the most pressing health care issues of the 1980s. Although the problem of medical indigency has existed for decades, it seems to have grown worse in recent years. It has certainly received greater attention on the part of state policymakers.

In 1984, for example, 22 states introduced legislation with the objective of improving the access of indigent people to medical care.<sup>1</sup> Since 1984, 14 states have organized legislative or gubernatorial study commissions with indigent care as a primary or secondary focus.<sup>2</sup> And it is likely this attention will continue for the near future, in part because many of the task forces have adopted a two-step process in developing recommendations. The first step usually results in partial solutions that will allow the task force more time to deliberate on the complex, long-term financing issues.

The causes of this heightened attention by the states are several: the recession of 1981-82 and the current lingering above-average level of unemployment; the leveling (i.e., marginal increases and decreases) in the number of Medicaid recipients that has resulted from state and federal funding cutbacks; and public and private sector efforts to contain rising health care costs.

Taken together, however, these three factors-- especially cost containment -- are shaping the way health care services are financed and delivered. Pressures from government and the business community to lower the cost of health care and the advent of new, more cost-effective insurance and delivery systems in response to those pressures are forcing hospitals and doctors for the first time to compete for patients. As their

traditional sources of revenue are squeezed, they have fewer resources to devote to caring for patients who cannot pay. That factor has shifted most of the burden to public hospitals and to the states to come up with the money needed to pay for additional indigent health care services.

The specific impact of each factor varies by state, and no study attempts to measure each factor's individual contribution to the indigent care problem. Nonetheless, it is apparent that collectively, the three factors have had key roles in exacerbating the old problem of assuring health care for the medically indigent.

### **Recession of 1981-82 and Unemployment**

In the United States, having a job and having health insurance are closely related. Unlike many other industrial nations, the United States has never enacted a national health insurance program and instead continues to rely on privately purchased health insurance. Employers usually offer group health insurance policies to their employees, and approximately 85 percent of the persons with private-sector health coverage obtain it through their employers.<sup>3</sup> Not only is group-purchased insurance less expensive than individually purchased insurance; employers often pay most of an employee's premium costs.

Thus, when unemployment is on the rise, as it was during the 1981-82 recession, the number of persons not covered by private health insurance increases. In 1983, the Congressional Budget Office estimated that one-third of the nation's uninsured lost coverage when they lost their jobs.<sup>4</sup> Furthermore, a study on health insurance coverage of the unemployed found that the longer people are unemployed, the more likely they are to lack health insurance coverage.<sup>5</sup>

Furthermore, unemployed workers are often precluded from public health insurance programs, such as Medicare and Medicaid, by the categorical restrictions on eligibility. A study by Berki et al. found that over 75 percent of the unemployed without private health insurance were not covered by Medicaid.<sup>6</sup>

Although the national unemployment rate declined from 10.8 percent in December 1982 to 7.0 percent in the fall of 1985, it is still above the unemployment levels of the 1960s and 1970s. In the foreseeable future, unemployment is likely to remain a significant contributing factor to the problem of medical indigency.

### **State and Federal Program Cutbacks**

The largest government program assisting persons who would



otherwise be medically indigent in obtaining health care services is Title XIX of the Social Security Act, otherwise known as Medicaid. Under this program, the federal government provides matching funds to states for the purpose of reimbursing providers who render necessary medical services to low-income persons meeting specific eligibility requirements.

Legislation creating the Medicaid program was enacted in 1965. During the first decade, Medicaid expenditures rose rapidly, with much of the costs attributable to the increasing enrollment that is common among new programs. By 1974, the rate of growth in the number of Medicaid recipients began to taper off, and by 1977, the number of recipients reached a program peak of almost 23 million.<sup>7</sup> Since 1978, the number of Medicaid recipients has varied between 21.5 and 22.5 million recipients.

This leveling in the number of Medicaid recipients did not result, however, in a leveling of program expenditures. During the period from 1975 to 1980, Medicaid expenditures grew by an annual average of 13.7 percent.<sup>8</sup> This rate was consistently higher than the growth in state and federal revenues--12.4 percent and 13.1 percent respectively. Although the growth rate of Medicaid expenditures declined to 9.6 percent in 1982, again it outstripped state and federal revenue increases--6.5 percent and 3.7 percent respectively. Thus, many states found Medicaid was absorbing an ever-increasing share of state general revenues.<sup>9</sup>

In 1981, the combination of a weak national economy that reduced the growth in state revenues and a reduction in the federal Medicaid matching rate forced 30 states to restrict Medicaid eligibility, benefits, or payments to providers.<sup>10</sup> These cutbacks were instituted during a period when the number of persons below the poverty level was increasing.<sup>11</sup> Pennsylvania, during the second year of the 1981-82 recession, devoted 42 percent of its revenue growth to finance increases in its Medicaid expenditures.<sup>12</sup> Another example of a state that devoted a greater share of state revenues is Michigan, which experienced a half-billion dollar decline in state revenues during the same time period and increased Medicaid expenditures by \$35 million.

The cumulative effect of such program cutbacks or restrictions in the face of a higher number of persons below the poverty level has been a reduction in the percentage of persons eligible for Medicaid. In 1976, 10.5 percent of the U.S. population received services under Medicaid; by 1982, the percent had declined to 9.5.<sup>13</sup> An alternative measurement of the decline in Medicaid coverage of low-income persons is to construct a ratio of Medicaid recipients to the number of persons below the poverty level. This ratio has declined from .92 in 1976 to .64 in 1982.<sup>14</sup> Although this measurement is imprecise, a declining ratio does suggest that persons recently added to the poverty population often do not qualify for Medicaid.<sup>15</sup>

Restrictions in government programs assisting the medically indigent were not limited to Medicaid. From February 1 to July 1, 1983, for example, Illinois suspended state funding for its Aid to the Medically Indigent program. Indiana's county-funded Hospital Care for the Indigent program (which took effect in January 1982) has encountered problems that have rendered it virtually ineffective. With the adoption of a "Proposition 13" type of law, counties have become so limited in their ability to raise revenues to fund the program that fewer than 5 percent of the total hospital applications for reimbursement were approved and only 12 percent were paid on a current basis.

In response to declining state revenues and a large deficit for the fiscal year 1983 budget, the California legislature instituted major reforms in its Medicaid and state indigent care programs. To control inpatient hospital costs under Medi-Cal, selective contracting for such services was enacted. The legislature also returned responsibility for providing necessary care to the medically indigent (referred to as the "medically indigent adult" population) to the counties. The state agreed to assist the counties with financing, but at a rate of 70 percent of the state's historical cost for providing care to the medically indigent adult population. Kansas, for fiscal year 1982, eliminated medical coverage for General Assistance - Medical Care Only recipients. Further changes affecting program eligibility and service utilization were instituted for fiscal year 1984, for MediKan (the successor to the General Assistance - Medical program).

### Efforts to Control Health Care Costs

Perhaps the most significant factor contributing to recent concern over care for the medically indigent is the public and private sectors' efforts to control health care costs. From 1973 through 1983, the average annual increase in national health care expenditures was 13.1 percent.<sup>16</sup> As a result, health spending has consumed a growing proportion of the GNP, from 7.8 percent in 1973 to 10.9 percent in 1983.<sup>17</sup> This sustained increase has forced purchasers of medical services -- government and business alike -- to implement various cost containment strategies, especially for the most expensive component of acute care, hospital services.

In October 1983, the federal government began implementing a prospective payment system for inpatient hospital services under Medicare. The system, which fixed payments in advance based on diagnosis related groups (DRGs), creates incentives for hospitals to deliver services more efficiently. Because the amount of payment is not tied to specific services provided or the length of stay for each admission, hospitals must provide the services in such a manner that the cost is less than the DRG payment or otherwise absorb the difference.



Following Medicare's lead, several states (Pennsylvania, Utah, Michigan, Ohio, New Jersey and Washington) have adopted similar DRG-based payment systems for inpatient hospital services under Medicaid. Also under the Medicaid program, two states (California and Arizona) have adopted competitive bidding for the purchase of hospital services. Moreover, as of January 1985, more than two-thirds of the states had implemented a prospective reimbursement system for Medicaid hospital inpatient services.

Health care cost containment efforts, of course, have not been limited to the public sector. With health care costs constituting a larger and larger share of their operating expenses, employers are pursuing different strategies to better control such costs. A popular approach for businesses in containing costs is to participate in a local health care coalition. By September 1984, 134 state or regional coalitions were in existence.<sup>18</sup>

Health care coalitions are usually comprised of purchasers of medical care, providers of medical care, and insurers and have as an explicit goal the containment of health care costs. The belief is that coalitions will enable members to become more sophisticated in understanding the intricacies of the health care system and, because of their large membership, will have a greater influence in changing the system. The methods used by the coalitions vary considerably and include: facilitating the collection of hospital cost data to assist members in developing employee health insurance plans, assisting members in designing more cost-effective benefit packages, and designing health promotion activities for employees.<sup>19</sup>

In response to the pressures from coalitions and other entities (such as administrators of public employee health insurance plans), providers and insurers are developing alternatives to the traditional cost-based, vendor-payment, reimbursement systems. Two popular alternatives are health maintenance organizations, (HMOs) and preferred provider organizations (PPOs).

Health maintenance organizations -- organized systems of health care that provide a comprehensive range of services on a pre-paid basis -- are not a new phenomenon, but they have recently experienced a surge in total membership. From 1970 to 1980, the number of persons enrolled in HMOs grew from 3 million to 9.1 million, and by December 1984, the number of enrollees reached 16.7 million.<sup>20</sup> In 1984, the growth in total HMO membership grew by a record rate of 22 percent.<sup>21</sup>

Preferred provider organizations -- arrangements between providers and at least one group purchaser whereby health care services are purchased for a specific population at a negotiated rate -- are also gaining in popularity as a vehicle for containing costs.<sup>22</sup> California in 1982 became the first state to enact legislation authorizing PPOs. By mid-1984, there were 37 PPOs in California, with 876 hospital and 74,000 physician

contracts serving half a million people.<sup>23</sup> Since the enactment of the California law, 16 additional states have adopted similar laws.<sup>24</sup>

Numerous Blue Cross companies have announced intentions of offering PPO programs to subscribers.<sup>25</sup> General Motors and the United Auto Workers partners in one of the nation's most comprehensive and generous employee benefit plans, have agreed to offer employees a program called the Informed Choices Plan. Under the plan, designed to save GM \$220 million annually, employees are offered a choice of three options for health insurance coverage: traditional Blue Cross, an HMO, or a PPO. Depending on the specific plan selected, employees receive additional services in return for greater utilization controls.<sup>26</sup>

Not only are insurers offering plans that are price competitive; even providers are beginning to offer insurance plans that control health care costs. Humana, Inc., a for-profit hospital chain, now offers a plan called Humana Care Plus. This plan guarantees employers that their premiums will not increase more than the consumer price index.<sup>27</sup> In return, employees must primarily use Humana hospitals for their inpatient care.

The effect these cost containment proposals have had on the indigent care issue is indirect but nonetheless significant. First, providers are receiving fewer funds than they would have received under a cost-based reimbursement system. They are less able to allocate resources for charity care and find it more difficult to locate additional resources to treat the "new" medically indigent resulting from the high unemployment rate and governmental cutbacks.

The second effect from cost containment proposals, which is closely related to the first, is the change in providers' attitudes resulting from a change in the national priorities of health care. While the governmental actions of the 1960's concentrated on reducing financial barriers to necessary health care, today the top health care priority is cost containment. The efficient provider is rewarded with adequate reimbursement that assures continued survival in the competitive marketplace. Administrators who continue to assure treatment to everyone who comes themselves to their hospital, regardless of their ability to pay, puts the institution at risk of not covering its costs. Such continued losses can only lead to a competitive disadvantage and possibly bankruptcy. Thus, hospitals, in response to this change in national priorities of health care, are very reluctant to provide charity care -- or at least additional charity care -- which, they argue, is a societal responsibility.



It is impossible to separate the magnitude of each of the three contributing factors because in large part they are affected by each other. The recession provided employers with a rationale for instituting major cost-saving changes in their employee benefit plans to cut business expenses. It also forced many states to cut back funds for many programs, including indigent care and Medicaid.

### Hospitals and Charity Care

The best way to demonstrate the effect these three factors -- unemployment, government cutbacks, and health care cost containment efforts -- have had on the provision of medical care for the indigent is to look at hospital administrators' reactions to these pressures. The restrictions in government programs and the high unemployment rate have increased the number of patients without public or private health insurance, while cost containment efforts are restricting the revenues that some hospitals receive. Thus, it is no surprise that hospital administrators have become acutely aware of costs -- especially those costs for which they are not reimbursed. Hospitals are actively seeking methods to reduce or control their levels of uncompensated care.

"Uncompensated care" is usually defined as the combination of a hospital's bad debts and charity care. "Bad debt" refers to unpaid bills for services rendered to patients who presumably can afford to pay but for one reason or another fail to do so. "Charity care" is that which is provided to people with little or no public or private insurance and with no resources to pay for the services (i.e., the medically indigent). Charity care is of more concern because bad debts presumably could be reduced by more aggressive collection efforts.

Traditionally, hospitals have provided some level of charity care, but that level has increased. In 1982, community hospitals incurred \$6.2 billion in uncompensated care -- \$1.7 billion in charity care (which constituted 1 percent of total hospital payments) and \$4.5 billion in uncompensated care. These figures compare with a 1978 level of uncompensated care that was estimated at \$4.5 billion -- \$1.3 billion in charity care and \$3.2 billion in bad debts.<sup>28</sup> In the past, hospitals were able to subsidize charity care by charging private insurers (e.g., Blue Cross and commercial carriers) and self-paying patients higher rates -- a practice commonly referred to as cost-shifting. As previously noted, however, many private insurers have adopted their own cost containment practices that preclude hospitals from charging higher rates to subsidize charity care. This move, in turn, has made hospitals reluctant to absorb additional charity care costs resulting from cutbacks

in government programs. In 1981 and 1982, about 15 percent of hospitals put some type of limits on the level of charity care they provided, and even some public hospitals restricted their level of charity care.<sup>29</sup>

Of the various types of hospitals -- for-profit, voluntary non-profit, and public -- it is the public hospital that has been most affected by high unemployment, government cutbacks, and efforts to control costs. Representatives of public hospitals have asserted that some for-profit and nonprofit hospitals have limited the increase in their charity care costs by transferring indigent patients to public hospitals. As a condition of receiving city or county government support, public hospitals often are required to treat anyone who comes to them for care, regardless of their ability to pay. In some areas of the country, this situation has resulted in an increase in patient dumping -- the transfer of patients whose medical bills are unlikely to be covered by insurance. A study of such patient transfers in the Oakland, California, area found that 63 percent of the patients had no medical insurance, 34 percent had Medicare or Medicaid coverage (which does not cover charges), and only 3 percent were covered by private insurance.<sup>30</sup>

The fact that the public hospitals receiving the transferred, uninsured patients are frequently in worse financial shape than the transferring hospitals has exacerbated their plight. Public hospitals usually provide much higher levels of charity care, serve more Medicaid and Medicare patients (which pay lower rates than commercial insurers), and serve fewer privately insured patients to whom they can shift their costs.

Government spending cuts and unemployment increases have occurred before and will occur again in the future. Thus, those two factors are not enough to explain the growing concern over the medically indigent. What makes the present period different are the health care cost containment initiatives. Because it is unlikely that cost containment efforts will subside in the near future, providers will be less able and willing to provide charity care to indigents. And as more businesses, insurers, and government agencies adopt aggressive cost containment policies, the problem of care for the medically indigent is likely to become even bigger.

The Intergovernmental Health Policy Project has produced this report to assist state and federal health policymakers in their understanding and analysis of the medically indigent issue. Chapter II summarizes national and state studies that have estimated the size of the uninsured population or have identified the key characteristics of the medically indigent. Chapter III provides a brief overview of the state sources of care for the medically indigent. Chapter IV profiles state- or

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state/county-funded programs that assist the medically indigent. These programs have never been fully documented before, despite the fact that some states and counties had established such programs before the Medicaid program was created. These programs are often the payer of last resort and provide medical services to those ineligible for other public health insurance programs.



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FOOTNOTES

<sup>1</sup> Recent and Proposed Changes in State Medicaid Programs: A Fifty State Survey, December 1984, Appendix pp.1-9, Intergovernmental Health Policy Project, George Washington University and Center for Policy Research, National Governor's Association, Washington, D.C.

<sup>2</sup> J. Luehrs and R. Desonia. A Review of State Task Force and Special Study Recommendations to Address Health Care for the Indigent, Center for Health Policy Analysis, National Governors' Association, and Intergovernmental Health Policy Project, George Washington University, Washington, D.C., November 1984.

<sup>3</sup> "Providing Health Coverage for the Unemployed", Staff Memorandum by the Congressional Budget Office, Washington, D.C., p.2, May 1983.

<sup>4</sup> Ibid., p.1

<sup>5</sup> S.E. Berki, M.A., Leon Wyszewianski, Ph.D., Richard Lichtenstein, Ph.D., Phyllis A. Gimotty, Ph.D., Joyce E. Bowlyow, Ph.D., M. Elise Papke, M.P.H., Tina B. Smith, M.S., Stephen C. Crane, Ph.D., and Judith Bromberg, Ph.D., "Health Insurance Coverage of the Unemployed", Medical Care, Vol. 23, no.7, July 1985, pp. 849-50

<sup>6</sup> Ibid., p.7

<sup>7</sup> Marilyn Riemer, Brian Burwell, Denise Madigan and Gerald Adler, Short-term Evaluation of Medicaid: Selected Issues, p.44, Urban Systems Research and Engineering, Inc., Cambridge, Massachusetts, January 1984.

<sup>8</sup> Ibid., pp.42-43

<sup>9</sup> Recent and Proposed Changes in State Medicaid Programs: A Fifty State Survey, April 1983, Appendix 2, Table I, "Percent of State Tax Supported General Revenues Devoted to Medicaid," Intergovernmental Health Policy Project, George Washington University, and Center for Health Policy Research, National Governor's Association; Washington, D.C.

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<sup>10</sup> Ibid., Introduction.

<sup>11</sup> Short-Term Evaluation of Medicaid, p.45.

<sup>12</sup> Ibid., p.42.

<sup>13</sup> Ibid., p.44.

<sup>14</sup> Ibid., p.45.

<sup>15</sup> Ibid., p.47.

<sup>16</sup> Ross H. Arnett, III, Carol S. Cowell, Lawrence M. Davidoff, and Mark S. Freeland, "Health Spending Trends in the 1980's; Adjusting to Financial Incentives", Health Care Financing Review, Vol. 6, No.3, Spring 1985, p.21.

<sup>17</sup> Ibid, p.8.

<sup>18</sup> "Number of Health Care Coalitions on the Rise", The Internist, February 1985, p.12.

<sup>19</sup> For further information on Health Care Coalitions, see Controlling Health Care Costs: The Role of Business Coalition, by the Alpha Center, Washington, D.C., August 1982.

<sup>20</sup> Ten Year Report, 1973-1983, by the Health Maintenance Industry Organization, produced by the National Industry Council for HMO Development, 1984. number 20, May 20, 1985.

<sup>21</sup> Health Care Competition Week, vol. 2, Number 20, May 1985, p.3.

<sup>22</sup> State Regulation of Preferred Provider Organizations: A Survey of State Statutes, Legal Developments Report Number 4, Office of Legal and Regulatory Affairs, American Hospital Association, March 1984, p. iv.

<sup>23</sup> Cindy Arstein-Kerslake, "California PPOs Are Expanding", CHA Insight, by California Hospital Association, vol. 9, Number 7, March 18, 1985.

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<sup>24</sup> A Survey of Preferred Provider Organizations, by AHA, and "Update on PPO Laws", State Health Notes, No.57, October 1985, Intergovernmental Health Policy Project, George Washington University, p.6.

<sup>25</sup> Health Care Competition Week, vol. 2, no. 8, March 4, 1985, p.1; vol. 2, no. 10, March 11, 1985, p.2; vol. 2, no. 13, April 1, 1985, p.3.

<sup>26</sup> Health Care Competition Week, vol 1., no. 8, October 1, 1984, p.5.

<sup>27</sup> Health Care Competition Week, vol. 1, no. 20, December 24, 1984, p.1.

<sup>28</sup> 12 Questions: What Legislators Need to Know About Uncompensated Hospital Care, National Conference of State Legislators and the Foundation for State Legislators, Washington, D.C., 1984.

<sup>29</sup> Frank A. Sloan, Joseph Valvona, and Ross Mullner, Identifying the Issues: A Statistical Profile, A paper presented at a conference entitled, "Uncompensated Hospital Care: Defining Rights and Assigning Responsibilities", Vanderbilt University, April 6-7, 1984, p.19; and "Public Hospital Limits Care to Tampa's Poor", AMA News, April 20, 1984, p.21.

<sup>30</sup> David V. Himmelstien, Steffie Woolhand, Martha Haruly, Micheal B. Buder, Ralph Silber, Howard D. Backer, and Alice A. Jones, "Patient Transfers: Medical Practice as Social Triage", American Journal of Public Health, Vol. 74, No. 5, May 1984, pp.494-497.



## CHAPTER II

### STUDIES ON THE MEDICALLY INDIGENT

The population groups included in "medically indigent" -- those with little or no public or private insurance and without resources to pay for essential medical services -- vary across state lines because of the tremendous differences in state and local programs. In many states, the only significant sources of public health insurance are the Medicare and Medicaid programs. In other states -- Maryland and Pennsylvania, for example -- general assistance recipients are automatically eligible for medical assistance, similar to the relationship between Medicaid and SSI and AFDC recipients. It is unclear how many studies estimating the size of the medically indigent population have made this distinction, but it appears few, if any, have been able to account for such variations in state indigent care programs.

This chapter describes some of the national and state studies that have generated information identifying key characteristics of the medically indigent. The first series of such studies mentioned attempts to estimate the percent of the population that lacks health insurance. The second series of studies describes the size and characteristics of the uninsured unemployed or uninsured poor -- two categories of individuals with a high risk of becoming medically indigent.

Although many attempts made have been made to estimate the size of the medically indigent population, different studies often yield seemingly conflicting results. Often these discrepancies arise because the studies adopt slightly different definitions of indigency or draw on different data bases. For example, some studies use different survey techniques (e.g., telephone interviewing versus interviewing in person), different definitions (e.g., some limit the population at risk to

people under 65), and different time periods (e.g., data collected during a recession will probably yield a higher percentage of uninsured people than data collected during an economic recovery).

In the report, Wisconsin's Uninsured: The Scope of the Problem and Alternative Solutions, Riemer encountered similar difficulties in comparing the different studies:

The methodological differences among the different studies are so great and so complex that even if the time and money were available, it would probably not be possible to reconstruct and manipulate the various study results so as to arrive at a single conclusion about the number of uninsured Americans. Nor is it clear that a single figure would necessarily assist the effort to design public policy, since the figure would change anyway from year to year as the economy expands or contracts, as tax laws change, etc.<sup>1</sup>

### Studies on the Uninsured

Many studies that examine some component of the medically indigent population focus on the uninsured. The lack of health insurance coverage -- either public (Medicare or Medicaid) or private -- usually presents a barrier to obtaining medical care. But the mere fact of having health insurance does not assure access to necessary care. Since private health insurance is purchased through many carriers, health insurance coverage often varies significantly. Some policies, for example, have tight dollar limits, some have significant cost-sharing provisions in the form of high deductibles or large copayments, and others may restrict coverage to the employee, by excluding the employee's dependents. With these cautionary notes in mind, some of the most cited studies on the uninsured are briefly described.

The 1977 National Medical Care Expenditures Survey (NMCES) by Kasper et al. estimated that 9.5 percent of the population under age 65 was always uninsured, and that an additional 8.3 percent was uninsured part of the year. The NMCES consisted of a series of six interviews per household, in a nationwide sample of 40,000 households, over an 18-month period during 1977 and 1978.<sup>2</sup> Individuals without Medicare, Medicaid, or private health insurance were defined as uninsured.

An article titled "Health Insurance for the Unemployed and Underinsured" (Blendon et al.) estimated that 12 percent of all Americans are without health insurance.<sup>3</sup> Of those with insurance, 20 percent had government-financed coverage and 68



percent had private insurance.

A more recent study by Schwartz estimated that 16 percent of the population under age 65 lacked health insurance.<sup>4</sup> This study was based on the current Population Survey, which includes a series of questions about household health insurance. A recently released Census Bureau report found that about 15 percent of Americans lacked health insurance during the fourth quarter of 1983.<sup>5</sup>

Recent studies by five states have yielded information on the size of their uninsured population. Tennessee, using a sampling of its population in mid-1984, found that only 7 percent lacked public or private health insurance.<sup>6</sup> According to a survey by the University of New Mexico, 20 to 23 percent of that state's population lacked public or private coverage.<sup>7</sup> A special survey conducted for the Colorado Task Force for the Medically Indigent in 1983 found 20 percent of the state's population lacked health insurance.<sup>8</sup> Wisconsin estimated its uninsured population in 1984 at 10.2 percent, and Minnesota estimated that, at any given point, 8.1 percent of the state's population will be uninsured in 1985.<sup>9</sup>

Having public or private health insurance coverage, however, does not guarantee payment of all large medical bills. The University of Colorado hospital found that 24 percent of its patients covered by the state-funded medically indigent program had some type of private health insurance that did not pay the entire hospital bill.<sup>10</sup> A recent study by Farley, based on the NMCES data, examined the inadequacy of health insurance coverage. It found that, "depending on the definition, from 8 to 26 percent of the privately insured population under age 65 is underinsured, with an intermediate estimate of 13 percent."<sup>11</sup> The author determined the range of inadequate private health insurance coverage by varying the definition and probability of incurring a costly illness. The report estimated that 27 percent of the under-65 population in 1977 either lacked health insurance for at least part of the year or had inadequate health insurance.

### **Studies on the Uninsured: The Unemployed**

In addition to the studies estimating the size of the uninsured population, several studies have identified the key determinants of whether or not a person is uninsured. The two most common factors are unemployment and low income, and although the two categories overlap, they differ significantly.

About 85 percent of the Americans who have private health insurance receive it as a fringe benefit of employment.<sup>12</sup> Thus, losing a job often means losing one's health insurance. A survey of workers receiving unemployment benefits in the Detroit metropolitan area (Berki et al.) found that 51 percent of the unemployed had no private health insurance and 38 percent had neither health insurance nor Medicaid.<sup>13</sup> Seventy-eight percent of these unemployed, uninsured workers had coverage while employed, however. The study also found that 42 percent of the unemployed who had health insurance obtained it by converting an employer-based policy or through inclusion under their spouse's policy. On a national level, one study estimated that 13 percent of those who lost their jobs during the 1982 recession were left without any insurance coverage.<sup>14</sup>

While employment increases the likelihood of health insurance coverage, many workers are still left out. Employers with small firms, farms, and nonunion companies tend to have a lower rate of coverage than do those with larger, unionized companies. The Colorado Task Force on the Medically Indigent estimated that 50 percent of the poor that were employed had no private health insurance. On a national basis, Schwartz estimates that one-fourth of the uninsured adults in 1982 were full-time workers for 40 weeks or more.<sup>15</sup> One reason that workers have no insurance may be the waiting period that employers impose before making insurance available. Over half of all jobs entail a waiting period before new employees are eligible for health insurance benefits.<sup>16</sup> Another reason is that many firms do not offer such benefits to part-time workers.

### **Studies on the Uninsured: The Poor**

The other major group of studies examining the uninsured focuses on the poor. One should be aware, however, that many of these studies use different measures of poverty. Some use the federal poverty level appropriate for a given year, while others use 125 percent or 150 percent of the federal poverty level.

Wilensky and Berk found that 15 percent of the poor were ineligible for Medicaid and lacked private health insurance.<sup>17</sup> They defined the poor as people with incomes below 125 percent of the poverty level in 1977 (which was \$10,000 for a family of four). In surveying people at below 150 percent of the 1983 federal poverty level (which was \$14,850 for a family of four), the Colorado Task Force found that 38 percent did not have health insurance.<sup>18</sup> A survey by the University of New Mexico reported that 9 percent of the households below the federal poverty line were uninsured versus 12 percent with incomes below 150 percent of the federal poverty line.<sup>19</sup>



## Summary

Although the specific characteristics of the uninsured vary by state, the group has some characteristics in common. For example, Mulstein notes that the young are disproportionately represented among the uninsured.<sup>20</sup> Depending on the state, those under age 18, those 18 to 24, or those 18 to 35 are frequently identified as having the lowest level of health insurance coverage. Differences also exist between urban and rural areas in the percentage of the population lacking insurance, with the rural group more likely to be uninsured. Mulstein also identified regional differences in insurance coverage. While 80 percent of those in the South and West are always insured (private and public, including Medicaid), in the Northeast and North Central areas almost 88 percent are insured.

Some generalizations about the uninsured or the medically indigent are valid. Nationally, about 15 to 16 percent of the population lacks public or private health insurance at any given time. And, because private health insurance coverage is closely tied to employment, the uninsured segment of the population increases during times of sustained unemployment.

Further, although the lack of insurance is directly related to income and employment status, many of the uninsured appear to be the working poor -- that is, someone in a low-paying job that does not offer health insurance as a benefit, who is never employed long enough at one place to qualify for health insurance benefits, or, if insurance is offered, is unable to afford the premium.

Perhaps the most important conclusion of the studies is that each state needs to conduct its own analysis to estimate the magnitude of the medically indigent problem within its boundaries. For example, Tennessee estimated its uninsured at 7 percent of the population, while New Mexico arrived at 20 to 23 percent. Other state studies found similar differences in the percentage of uninsured when broken down by age, income, sex, employment, and other criteria. Such variations are expected given the different demographic characteristics of each state, as well as the different eligibility standards and benefits coverage under the state medical assistance programs.



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FOOTNOTES

<sup>1</sup> David Riemer, Wisconsin's Uninsured: The Scope of The Problem and Alternative Solutions, Milwaukee, Wisconsin, December 24, 1984, p.5

<sup>2</sup> J. Kasper, D. Walden and G. Wilensky, "Who are the Uninsured?" National Health Care Expenditures Study, Data Preview 1, National Center for Health Services Research, Department of Health and Human Services.

<sup>3</sup> R. J. Blendon, D. E. Altman, and S. M. Kilstein, "Health Insurance for the Unemployed and Uninsured", National Journal, Vol. 15, No. 22, pp.1146-59.

<sup>4</sup> Katherine Schwartz, Urban Institute, "The Changing Face of the Uninsured", Paper presented at the Annual Meeting of the Association for Health Services Research, June 1984.

<sup>5</sup> "Economic Characteristics of Households in the United States: Fourth Quarter 1983", U.S. Census Bureau, U.S. Department of Commerce, Washington, D.C., 1985.

<sup>6</sup> Frank A. Sloan, Joseph Valvona, and Gerald B. Hickson, Analysis of Health Care Options in Tennessee: Uncompensated Care, Vanderbilt University, January, 1985, p.18

<sup>7</sup> Lynn Wombold, Brian McDonald, Gerald Boyle, and Max Bennett, Health Care Coverage and the Medically Indigent in New Mexico, New Mexico Department of Health and Environment, February 1984, p.48.

<sup>8</sup> Report of the Colorado Task Force on the Medically Indigent, Colorado's Sick and Uninsured: We Can Do Better, Vol. 1, January, 1984, p.6.

<sup>9</sup> David R. Riemer, Wisconsin's Uninsured: The Scope of the Problem and Alternative Solutions, Milwaukee, Wisconsin, December 24, 1984, p.24; and David L. Kennel and John F. Sheils, Analysis of Health Care Coverage and Health Care Utilization and Expenditures in Minnesota for 1985, Minnesota Health Planning Agency, November 1984, p.iv.

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<sup>10</sup> Colorado's Sick and Uninsured, Vol. 1, p.6.

<sup>11</sup> Pamela J. Farley, "Who Are The Uninsured?", National Center for Health Services Research, U.S. Department of Health and Human Services; presented at the American Public Health Association, November 13, 1984, p.1

<sup>12</sup> Staff Memorandum, Congressional Budget Office, "Providing Health Coverage for the Unemployed", May 1983, p.2.

<sup>13</sup> S.E. Berki, M.A., Leon Wyszewianski, Ph.D., Richard Lichtenstein, Ph.D., Phyllis A. Gimotty, Ph.D., Joyce E. Bowlyow, Ph.D., M. Elise Papke, M.P.H., Tina B. Smith, M.S., Stephen C. Crane, Ph.D., and Judith Bromberg, Ph.D., "Health Insurance Coverage of the Unemployed", Medical Care, Vol. 23, no.7, July 1985, pp.849-50

<sup>14</sup> Alan C. Monheit, Michael M. Hagan, Marc L. Berk, and Gail R. Wilensky, "Health Insurance for the Unemployed: Is Federal Legislation Needed" Health Affairs Vol. 3, No.1, Spring 1984, p.101.

<sup>15</sup> Katherine Schwartz, "The Changing Face of the Uninsured."

<sup>16</sup> R. J. Blendon, et al, p.1146.

<sup>17</sup> Gail R. Wilensky and Marc L. Berk, "Health Care of The Poor and Medicaid" Health Affairs Vol. 1, No. 4, Fall 1982.

<sup>18</sup> Colorado's Sick and Uninsured, p.6.

<sup>19</sup> Wombold, Medically Indigent in New Mexico, et al, p.54.

<sup>20</sup> Suzanne Mulstein, "The Uninsured and the Financing of Uncompensated Care: Scope, Costs, and Policy Options", Inquiry Vol. 21, No. 3, Fall 1984, p.214-229.





## **CHAPTER III**

### **INTRODUCTION TO STATE PROGRAMS THAT ASSIST THE MEDICALLY INDIGENT**

State assistance programs for the medically indigent vary widely in design and implementation. This chapter summarizes the major state programs. Because the purpose of this report is to document state programs that assist the medically indigent, county-administered programs and state programs that rely on federal assistance, such as Medicaid, were specifically excluded. For information on the types of programs included in states' profiles, see "Part A: Explanation of State Profile and Terms" in Chapter IV. To appreciate the broad array of government programs that assist the medically indigent, however, it is important to understand the Medicaid and county-administered programs.

The remainder of this chapter discusses indigent care programs under the following headings:

- **Medicaid**
- **State and County Programs for the Medically Indigent\***
- **Hospitals, Charity Care, and Certificate of Need\***
- **Other Limited State Programs\***
- **Continuation and Conversion of Health Insurance†**
- **Catastrophic Health Insurance Programs\***
- **Risk Pools\***
- **Indigent Care Provisions Under Rate-Setting States\***

\* A program included in the state profile.

† See Appendix A.

## Medicaid

Medicaid, a state-federal program of assistance for low-income people who meet certain financial and categorical criteria, provides medical care for those who, without the program, would be considered medically indigent. Therefore, it is necessary to explain the Medicaid program to understand whom it serves and how other indigent care programs may complement Medicaid. For example, neither Alaska's nor Montana's Medicaid program pays for prescription drugs; however, prescription drugs are covered under their respective indigent care programs. Hence, Medicaid recipients may receive such benefits if they meet the program's income standards.

Medicaid, jointly financed by the federal and state governments, pays for the medical care of the aged, blind, disabled, and children and mothers in needy families. All Aid to Families with Dependent Children (AFDC) recipients and most Supplemental Security Income (SSI) recipients (the aged, blind, and disabled) are automatically covered by Medicaid. In addition, states have the option (with federal matching support) to cover other categories of recipients, e.g., the medically needy -- those whose incomes are too high to qualify for AFDC or SSI but who fall below the state-established maximum income standards when their medical bills are deducted from their incomes. Medicaid had grown into a \$37.3 billion program by 1984, providing approximately 21.5 million recipients with a wide range of medical services, including hospital, physician, laboratory, X-ray, and nursing home care.

Given the many options states have under the Medicaid program, each state's program is unique and the system as a whole, complex. Although states must provide a set of basic services, they may also choose to provide as many as 30 optional services, such as drugs, eyeglasses, and dental services. Minnesota offers all but one optional service. On the other hand, a few states cover only 12 of the 30 optional services.

With respect to mandatory services, states still can set limits on the amount, duration, and scope of a particular service. For example, although hospital inpatient services are a mandatory benefit, in 1983 one-third of the states imposed a ceiling on the number of days they would reimburse. In 1983, Florida had a 45-day-per-year limit on inpatient hospital coverage, West Virginia had a 20-day-limit, and Tennessee had a 14-day limit.<sup>1</sup>

The list of Medicaid complexities continues, with differences in program administration, methods of reimbursement, and

eligibility standards. For example, because states have considerable discretion in establishing certain eligibility standards, a person with a given income and set of resources may be eligible in one state but ineligible in a neighboring state.

Even with the variations in coverage, Medicaid remains the major provider of care for individuals who otherwise would be medically indigent. Many states, especially those that have established indigent care task forces, have adopted legislation expanding the size of the state Medicaid program. Such actions include expansion of services -- West Virginia; expansion in eligibility -- North Carolina; and creation of a medically needy program -- Florida, Georgia, Iowa, and South Carolina. The most innovative approach in changing a state Medicaid program is Florida's method of financing its eligibility expansions. Each hospital is assessed 1.5 percent of its net operating revenue. The funds are deposited in the Public Medical Trust Fund, which is used as the state matching money for the expansion in Medicaid eligibility. Another interesting component is Florida's decision not to cover long-term care services under the newly created medically needy program.

A chart summarizing covered services under state Medicaid programs as of October 1983 is included in Appendix B.

### **State and County Programs for the Medically Indigent**

Every state has adopted legislation authorizing various levels of government to provide certain health and medical services for its residents. And in all but three states, either the state or local government is expressly obligated by law to provide at least some health services to some indigent populations.<sup>2</sup> Of the 50 states, 34 have a state indigent care program. The term "state indigent care program" refers to a government program administered by the state, or jointly administered by the state and county, that provides some level of medical services to indigents unable to afford such care because they lack adequate health insurance or resources to purchase such services, and who do not qualify for other public assistance programs, most notably Medicaid.

#### **A. County Programs**

Of the 16 states without a state indigent care program, responsibility for providing medical care to indigents rests largely with the county, although a few states do not specifically assign any responsibility. In states that assign responsibility to the county, the type of indigent care programs varies immensely from county to county. In its Final Report on



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Indigent Health Care, a task force in Texas thus summarizes its local system:

Reliance on local government programs varies across the state, depending on the level of need for services in the community and the existence of other health resources able to serve the needy. In some areas of the state, federally funded Community Health Centers provide comprehensive primary care services. In other places, nonprofit hospitals provide a substantial amount of care to indigents and reduce the demand for local government-funded services. Some areas have postgraduate physician training programs which may provide care to indigents.

In the large metropolitan areas of a state, it is common to find the county either operating or financing a public hospital that, as a condition of receiving the county funds, agrees to treat all indigent county residents presenting themselves to the hospital.

As noted in Chapter I, many public hospitals have been experiencing financial stress due in large part to the higher levels of charity care they provide and the correspondingly lower level of privately insured patients treated. (More information on public hospitals is provided in this chapter under "Hospitals, Charity Care, and Certificate of Need.")

While many large counties are struggling with constantly increasing budgets for public hospitals, the most frequent problem encountered by small counties is adopting a budget that anticipates medical bills that often fluctuate widely from year to year. To assist counties in making their indigent care bills more predictable, South Dakota enacted in 1984 a catastrophic county poor relief fund. The fund will reimburse a county for costs in excess of \$20,000 for any individual eligible for county relief. The Idaho Association of Counties established a catastrophic fund to insure counties against expensive individual claims. Both South Dakota's and Idaho's programs are totally funded by the participating counties.

#### B. State-County Programs

The 34 states with indigent care programs administer a total of 41 programs. Twenty-nine (29) states have a single program providing some medical services to the indigent, and four states (Illinois, Michigan, New Jersey and Washington) have two indigent care programs. Virginia operates the most, with four indigent care programs. One program reimburses hospitals for inpatient care, another is tied to the county general assistance program and reimburses providers for ambulatory services,

and two groups of hospitals -- the state teaching hospitals and the Eastern Virginia Medical Authority -- receive substantial state funding for financing indigent care.

Three of the states with multiple indigent care programs have tailored their programs to be complementary with one another. Michigan's programs are complementary in terms of service coverage: the Resident County Hospitalization program covers inpatient hospital services, and the General Assistance program covers ambulatory care. Because the eligibility standards of the two programs are established by different entities (the county establishes the standards for the hospitalization component and the state develops the standards for the ambulatory component), the programs are not complementary in terms of eligibility. For example, an individual could be eligible for ambulatory services but not qualify for hospitalization.

Illinois and Washington, however, do have programs with complementary eligibility standards. Both states have their major indigent care programs tied to the general assistance program, whereby general assistance recipients automatically qualify for medical assistance. Counties are not obligated to participate in the Illinois general assistance program and many do not. Thus, the state-administered and -financed Aid to the Medically Indigent program was created for those persons ineligible for Medicaid and residing in a county without a general assistance program. Washington's General Assistance-Unemployment and the Limited Casualty programs serve similar purposes.

At the time this report was being prepared, four states had not implemented recently adopted legislation requiring the creation of a state indigent care program. Oklahoma passed such legislation in 1984, mandating the creation of the Indigent Health Care Program. A 1984 state referendum to raise the constitutional limits on the county ad valorem tax, did not pass. Such an increase was necessary for counties to finance care for the medically indigent and to receive state financial assistance. In their 1985 session the legislature deleted this section of the act, thereby allowing counties to implement the act--albeit at a lesser funding level than was originally intended in the 1984 act. The other three states -- Arkansas, South Carolina, and Texas adopted major indigent health care legislation in 1985, and are in the planning stages for implementing the acts in 1986. Nonetheless, these states were considered as having a state indigent care program and are included in all the descriptions of state indigent care programs.

### *1. State-County Programs: Administrative Responsibilities*

In any indigent care program, the state or the county must assume certain administrative functions: establishing the



eligibility standards, conducting the eligibility determinations, deciding which medical services will be reimbursed, and processing providers' claims. Seventeen (17) states administer all components of their indigent care program; in the remaining 17, the state and the counties share the administrative responsibilities.

Second in importance to the funding of an indigent care program is establishment of eligibility standards. In 26 states, the state government is responsible for establishing eligibility standards for the indigent care programs, while in the other 8 states with such programs, eligibility is determined by the county or the state and county. The advantage of the state approach is that eligibility standards (and benefit coverage) will more likely be uniform across county lines.

## *2. State-County Programs: General Assistance Programs*

Twenty-two (22) states have an indigent care program that is associated with a state or county general assistance program. General assistance programs (also called general relief, home relief, and poor relief in some states) are state or local programs of continuing or emergency income assistance. These programs serve as the ultimate "safety net" for poor people and families ineligible for federally supported assistance programs like AFDC and SSI.<sup>3</sup> Benefit levels vary from small, one-time-only payments to meet immediate needs to regular payments virtually identical to AFDC or SSI. Historically, the administration of the general assistance programs was the responsibility of the county or town, but over the years states began to assume some of the responsibility for the administrative or financial components of the program. Such states as Kansas and Maryland have assumed total administrative and financial responsibility for their general assistance programs, including the medical services component.

It is common to find these programs designated as General Assistance-Medical programs which implies the General Assistance program and the General Assistance-Medical program are separate and distinct programs. In fact all but 3 of the 22 GA-Medical programs are actually the medical services component of the general assistance programs. In the 19 states, a recipient of cash assistance from the general assistance program is automatically eligible for services under the medical component. In the other three states -- Alaska, Virginia, and Wisconsin -- a general assistance recipient must apply separately for medical assistance, or the state allows the county to determine whether to adopt an automatic eligibility provision.



### *3. State-County Programs: Optional State Assistance*

One variation in the state indigent care program is the state-created optional program that provides state assistance for participating counties. Eight (8) states have such optional programs, four of which are tied to a general assistance program. New Jersey's General Assistance-State Medical Match program provides a 75 percent state match for medical services provided to any indigent meeting state eligibility criteria. Municipalities must conduct the eligibility determination and process providers' claims. Nonparticipating municipalities must still administer a program to assist indigent residents, however the state does not provide administrative or financial assistance for such local programs. Virginia and Michigan have similar optional programs that assist counties in financing hospital care for county indigents.

Not all optional state programs are tied to the general assistance program, however. For example, under Utah's optional Indigent Medical Assistance program participating counties must contribute a 1/4-mill levy of the county's total assessed property value to the state. In return, the state sets uniform eligibility criteria, certifies an applicant's eligibility, reimburses providers, and finances all program costs that exceed the county assessment. If a local unit of government elects not to participate in the Utah program (and this is true for all optional state programs except Virginia's) the county is responsible for administering its own program.

{Author's Note: California's County Medical Services Program is not considered an optional program in the same sense as the other eight state programs. The state County Medical Services Program is only available to small counties (under 300,000 population) and if the county elects not to participate, the county will still receive state funds under the Medically Indigent Services Program. In the other eight state programs (which are not limited to small counties), if the county elects not to participate the state will not provide any funding to the county program.}

### *4. State-County Programs: Uniformity of Standards*

A major advantage to state administration of an indigent care program is the uniformity of eligibility standards and benefit coverage across county jurisdictions. In states that rely on counties to provide services to the medically indigent, those counties that have established less restrictive eligibility standards (or counties that operate a public hospital) often find themselves treating out-of-county residents. One county

may bill another county where the indigent person resides; however, the collection process is often cumbersome, even in states like Florida and Indiana, which have a formal payment system delineating intercounty payment requirements.

Uniform state programs prevent such problems, even in some states with optional state programs because counties participate to such a degree that their total population represents a large majority of the state's population (such as New Jersey and Rhode Island). Twenty (20) states had uniform programs in that the eligibility standards and services provided were identical across county lines. An additional three states which have two indigent care programs (New Jersey, Illinois, and Michigan) have one uniform program. As expected, in all states with uniform state indigent care programs, the state was responsible for establishing eligibility standards and determining service coverage.

#### *5. State-County Programs: Hospital-Based*

Although the general assistance programs and the optional state programs are the most common state indigent care programs, two states have programs based on a state hospital or network of hospitals. The most famous is Louisiana's Charity Hospital System, established in the 1930s under Governor Huey Long. Nine state hospitals receive funds to cover the cost of providing inpatient and outpatient hospital care to indigents meeting state eligibility standards. The hospitals determine eligibility. Iowa's State Papers program is unique in that each county, which is legally responsible for providing medical care for its indigent residents, is allotted a quota of indigent residents who may be treated at the University of Iowa Hospital and Clinics without charge. The state annually appropriates an amount -- \$24.5 million in 1984 -- to the University of Iowa Hospital for providing care to indigents. For indigents residing in distant rural areas a statewide transportation service to and from the University of Iowa Hospital in Iowa City was established.

#### *6. State-County Programs: Services*

Sixteen (16) of the 34 states with indigent care programs cover both hospital and ambulatory services similar to those mandated services provided under Medicaid. By law, Medicaid must provide inpatient and outpatient hospital services, physician services, lab and X-ray procedures, rural health clinics, home health services, and skilled nursing facilities services. Frequently, however, states put greater restrictions on services provided under their indigent care programs. For example, Oregon limits inpatient hospitalization for 18 days per year for



Medicaid recipients and 12 days per year for general assistance recipients. Maryland's general assistance program requires a \$0.50 copayment on prescription drugs but makes no such demand under its Medicaid program.

Another nine (9) states have programs that cover basic hospital and ambulatory services while four (4) restrict coverage to just hospital services, two to ambulatory services and three states allow the county to determine which services to cover.

Coverage of long-term care under state indigent care programs is rare, and in those states covering such services, long-term care services usually account for a very small percentage of the program's expenditures. For example, Illinois's General Assistance program devoted less than 1 percent of its medical expenditures to nursing home care in 1983.

Some states with a broad range of hospital and ambulatory services broke down their program expenditures by service. Of those states reporting, inpatient hospital services constituted most of the programs' costs. Kansas, Maryland, Minnesota, Utah, and Washington reported that their inpatient costs constitute about 66 percent of the total. Outpatient hospital and physician services were second, accounting for 20 to 25 percent of program costs. Drugs usually constituted 5 to 10 percent.

Some states instituted various restrictions on provider participation or reimbursement. Eight (8) states require the provider to participate in the Medicaid program to receive payment under the state indigent care program. Very few reported a requirement that services, except in emergencies, must be previously authorized to ensure reimbursement. One state, Colorado, requires participating providers to provide a level of charity care equal to 3 percent of adjusted operating expenses based on the previous year's operating expenses. This charity care requirement is in addition to any Hill-Burton obligation.

## *7. State-County Programs: Expenditures*

The last important aspect of state indigent care programs is expenditures. In fiscal 1983, IHPP estimates that states and counties spent over \$2.3 billion for care provided under the state indigent care programs. This figure is probably low because not all county expenditures under state indigent care programs are included. For example, California's profile of the Medically Indigent Service program does not include county expenditures, and expenditures for the indigent component of the Arizona Health Care Cost Containment System are not available. In addition, expenditures under the limited state



indigent care programs and other state or county programs assisting the medically indigent were left out of in the \$2.3 billion estimate. Three states (New York, California, and Pennsylvania) accounted for 59 percent of the \$2.3 billion, and seven states accounted for 81 percent.

Eighteen (18) states totally funded the state indigent care program. All but one of the remaining states had programs that were financed jointly by the state and the locality, usually the county. The state/local share in those states ranged from 50/50 state-county (New York) to 92 percent by the state (Connecticut). The programs in Ohio, New Jersey, and Virginia were 75 percent state financed, which constituted the middle range.

South Carolina has the most unique source of funding of all the state indigent care programs. The counties and hospitals in the state are assessed in a manner that assures each group contributes equally to the Medically Indigent Assistance Fund. This fund is to finance hospitals that provide care to eligible people.

### **Hospitals, Charity Care, and Certificate of Need**

In the past, the most common sources of support for the medically indigent were locally-funded public hospitals. Even today, most states authorize counties or towns to operate hospitals, often with an accompanying provision that if they do so, they must serve the poor without charge or at a discount.<sup>4</sup> Public hospitals remain an important source of care for the medically indigent, especially in urban areas.

Many public hospitals, as mentioned earlier, have been experiencing financial difficulties.<sup>5</sup> In large part, the difficulties have been exacerbated by an increase in their charity care load. When compared to similar private hospitals, public hospitals provide a disproportionate share of uncompensated care. Both teaching and nonteaching public hospitals delivered 35 percent of the nation's uncompensated care in 1982 but accounted for only 18 percent of the total charges.<sup>6</sup> The financial health of many public hospitals is not good, and several have closed in the past few years. California, for example, has seen its public hospital system shrink from 65 hospitals in 1964 to 29 in 1982.<sup>7</sup>

Several factors contribute to their poor financial health. For one thing, hospitals usually depend on counties to provide some level of funding. As medical costs and patient demand for charity care services at public hospitals have increased, many counties have been unable to increase funds at the same pace,

in large part because of tax restrictions imposed by voters. This loss of funds is crucial because public hospitals tend to have a smaller pool of privately insured patients to whom they can shift costs. In addition, public hospitals are often not sufficiently reimbursed to meet their costs. For example, in 1979, California private hospitals received patient care revenues 3 to 5 percent in excess of their costs, while county public hospitals received 27 percent less than their costs.<sup>8</sup>

Other hospitals, nonprofit and for-profit, also provide charity care to the medically indigent. In 1982, voluntary nonteaching and investor-owned hospitals provided 42 percent and 5 percent, respectively, of the total amount of uncompensated care.<sup>9</sup> Yet those hospitals were responsible for 53 percent and 8 percent, respectively, of total 1982 hospital charges. Unlike public hospitals, it appears that the level of uncompensated care provided by private hospitals has not increased in recent years.<sup>10</sup>

Several state legislatures have proposed bills that would require hospitals to provide a minimum level of charity care. In 1984, Kentucky proposed a bill mandating hospitals to provide a "fair share" of charity care -- defined as the average level of charity care provided by the state's hospitals -- or face a stiff financial penalty. Funds from the fines would have been redistributed to hospitals providing a level of charity care that exceeded the state average. This proposal and similar ones in other state legislatures did not pass in 1984.

In 1985, several state legislatures -- California, Oregon, Tennessee, and West Virginia -- considered bills that would assist hospitals by reimbursing some of the hospital charity care. Many of the proposals adopted components of the Florida hospital assessment law. At the time of this writing, only South Carolina has adopted legislation specifically addressing the hospital charity care problem. The law creates a medically indigent assistance fund, financed by a hospital and county assessment, that will compensate general acute care hospitals for providing medical care to the indigent.

A few states have adopted policies that, under certain circumstances, tie certificate-of-need (CON) approval to the applicant's level of charity care. The state of Washington enacted a law that directs the state CON authority to compare a hospital's level of charity care to the regional average during a CON review. The same law directs the hospital rate setting commission to ensure that no hospital adopts admission practices that result in a significant reduction in the proportion of patients without third-party coverage. (The governor vetoed a provision of the law that mandated rejection of any CON application by a hospital not meeting the regional average of charity care.)

The state of Georgia issued a regulation in 1984 that requires parties purchasing or leasing a public hospital to provide an



amount of charity care equal to 3 percent of the hospital's gross revenue for the sale or lease to be approved. California enacted a law that directs the state to exempt health care projects from the CON process if the facility agrees to provide charity care for a five year period at an annual dollar level equal to at least 10 percent of the project's value. California's CON statute is being phased out and is slated for repeal in 1987. The District of Columbia requires the health planning agency to make written findings before a CON approval that a facility is providing a reasonable volume (3 percent of operating expenses minus reimbursement of Medicaid and Medicare) of free or below-charge care. South Carolina has adopted a policy that requires all health care facilities to include an indigent care plan in their CON application. These plans must reflect a commitment to identified community needs.

### Other Limited State Programs

Many states have a health program designed to reach a small target population or supplement existing federal, state, or locally funded medical service programs. The state profiles in Chapter IV do not catalog all of these programs; instead, they report data only on those programs that state health policymakers identified in the survey as alternatives or supplements to other indigent care programs. Thus, program descriptions should be considered illustrative rather than exhaustive. As the range of services and numbers of people they serve can be quite restrictive, these programs should really be viewed as supplementary to rather than substituting for state indigent care programs. Nevertheless, they do fill in some gaps in coverage and provide some individuals with significant benefits.

These programs are characterized chiefly by their diversity. Several states operate disease-specific programs for people suffering from renal disease, sickle cell anemia, cancer, hemophilia, blindness, tuberculosis, and so on. Florida and Missouri provide funds for high-risk women and babies, and Florida has committed a sizable sum, estimated to be \$24 million for FY 1984, to its perinatal program. Wisconsin provides a broad range of medical services to Native American residents, and Nebraska provides both cash and medical assistance for temporarily disabled residents. Minnesota and Kentucky give direct subsidies to hospitals for indigent care. Finally, Maine, Pennsylvania, Illinois, New Jersey, and Maryland provide pharmaceutical assistance for aged or disabled persons who meet income eligibility criteria.



### Continuation and Conversion of Health Insurance

The relationship between lack of insurance and medical indigency is clear. Obviously, those who lack health insurance are more likely to become medically indigent in the event of a serious illness than those who are adequately insured. The goal seems equally clear: to increase the percentage of people with adequate insurance. Nineteen states have enacted laws requiring insurers to permit those whose health insurance policies have been terminated, usually through lay-offs, to continue their policies for anywhere from 30 days to one year, depending on the state. Policyholders pay the entire premium but receive the benefit of group rates rather than the more expensive individual rates. Thirty-one states have enacted conversion statutes requiring insurers to permit those whose policies have been terminated to convert from group to individual policies.

Both continuation and conversion policies provide extended health insurance for people who might otherwise be uninsured. They are expensive, however, and are probably not purchased by people who are already medically indigent.

A chart summarizing state requirements for offering continuation and conversion options is presented in Appendix A.

### Catastrophic Health Insurance Programs

A few states have created catastrophic health insurance programs designed to mitigate the financial effects of lengthy, costly illnesses. Alaska, Maine, and Rhode Island operate catastrophic programs; Minnesota had a similar program until 1981 but terminated it in the face of rising health care costs and the weak economy. Each of these states has structured its program somewhat differently, but the purpose and operation are similar. People who suffer catastrophic illnesses must exhaust their own insurance coverage, if any, and then pay deductibles. The state will then pick up the remainder.

To discourage participation by people who are poor before becoming ill, deductibles are not nominal. In Rhode Island, for example, the minimum deductible is the greater of \$1,035 or 10 percent of income for those with comprehensive health insurance. Those without health insurance are required to pay the greater of \$10,350 or 50 percent of allowable income. Alaska requires participants to pay the first \$5,000 of costs, and Maine, at a minimum, requires participants to pay 30 percent of costs plus 10 percent of their net worth over \$20,000 and a \$7,000 deductible.

All three programs have substantially increased their deductibles in the past few years to target benefits to people suffering catastrophic illnesses and to control costs. Before the deductibles were raised, many people were using the catastrophic programs instead of buying their own health insurance.

Thus, catastrophic insurance programs are successful in protecting limited numbers of people from the devastating expenses of a catastrophic illness, but all been restructured in recent years to prevent them from serving as health insurance programs for indigents.

### **Risk Pools**

Nine states (Connecticut, Florida, Indiana, Minnesota, Montana, Nebraska, North Dakota, Rhode Island, and Wisconsin) have comprehensive health insurance associations, more frequently called risk pools. The risk pools are designed to protect people who cannot buy insurance because of their poor health status, even if they can afford the premiums. The premiums, however, tend to be expensive, ranging from 125 to 150 percent of those charged to standard-risk persons. As a result, only a limited number of people purchase insurance through state risk pooling associations, and so, even with substantially higher premiums, the pools do not generate enough revenue to be financially self-sufficient. Most states assess major insurers in the state for the difference between premium income and expenses, allowing them to claim the difference as a tax deduction.

By assisting nonpoor, uninsurable people to obtain adequate insurance, state risk pooling associations fulfill an important but limited role in the health insurance marketplace. Still, premium costs keep those programs out of the reach of poor people, for no state has been willing to subsidize the cost of the premium for low-income uninsurables. One state, Wisconsin, has completed a preliminary study on subsidizing health insurance premiums for the poor.

A report, Wisconsin's Uninsured: The Scope of the Problem and Alternative Solutions, suggests six optional health insurance proposals, all of which are based on the principles of competitive bidding and capitated payments. The state would not offer the health insurance itself but would encourage private insurers to develop such plans. The state's role would be limited to: subsidizing the costs not covered by the premiums, providing outreach and information services, developing eligibility standards, and monitoring beneficiary participation and contributions.

Although the legislation requiring the report requested two



alternatives, the report developed six because of the complexity of the issue and the wide range of options available. The overall tone of the report is cautious as the result of the dearth of experience in subsidizing private health insurance premiums, and it identifies several problems that need further study. The author of the report emphasizes he has only scratched the surface of the issue of providing health insurance to the uninsured, adding that "a dozen major issues -- and hundreds of minor issues -- related to eligibility, targeting, benefits, cost containment, administration, and implementation still remain to be analyzed in greater depth."<sup>11</sup> The report notes that full implementation could take five to ten years and would entail substantial state spending.

### **Indigent Care Provisions Under Rate Setting**

Nine states have implemented or are about to implement rate-setting systems. Four states (Maryland, Massachusetts, New Jersey, and New York) obtained waivers from the federal government permitting them to set rates for Medicare payments based on their respective rate setting methods. Wisconsin has implemented a rate setting mechanism that covers only Blue Cross and commercial payers. Each system operates differently, but all implemented rate settings programs include some provisions for uncompensated care. New Jersey's system is based on DRGs. A hospital's payment is increased by an uncompensated care factor that reflects its ratio of uncompensated care to gross revenues. Medicare, Medicaid, and Blue Cross receive discounts; all share in both bad debt and charity costs.

In Massachusetts, a system for reimbursing uncompensated care costs went into effect October 1, 1984. Under the system, uncompensated care costs are explicitly identified and built into each hospital's maximum allowable cost ceiling and reimbursed up to specified limits. Medicare and Medicaid share in limited amounts of charity care costs but not bad debts. Medicare pays up to 1.4 percent of charity care costs for its proportionate share of the market, and Medicaid pays for its proportionate share of charity care costs in facilities that derive at least 68 percent of their revenues from public sources.

Maryland's rate-setting system establishes rates in several ways, but charity care and bad debt payments are calculated the same way under all systems. Hospitals are paid for uncompensated care costs at the lesser of (1) the previous year's actual costs; (2) whatever they request; or (3) whatever the commission determines to be reasonable. Uncompensated care costs averaged 5.7 percent of gross revenues in FY 1983.



New York has the most complicated system of reimbursing for charity care and bad debts. The state builds reimbursement for these costs into each hospital's rate structure, but it also has created regional pools for spreading these costs across all facilities in the system. The pools are financed by a surcharge on hospital payments from third-party and public payers as well as a tax on charges for self-pay patients. Separate pools were established for private and public hospitals -- a step that has provoked some controversy because private hospitals receive higher reimbursements than public facilities. Private hospitals receive an average of 48 cents for each dollar they spend in charity care and bad debts, compared to 6 to 8 cents for public hospitals.<sup>12</sup> (Authors' Note: The Medicare Waivers for Maryland, Massachusetts, New Jersey, and New York expired in 1985; therefore, the specific state regulations have most likely changed since this report was written.)

Five other states (Connecticut, Maine, Washington, West Virginia, and Wisconsin) have or are about to implement mandatory hospital rate-setting systems. Some of these states do not plan to seek a waiver to include Medicare in their programs. All four either are required by law to include reimbursement for uncompensated care in their systems, or have announced an intention to include such reimbursement. Only Maine has a specific policy on uncompensated care; its system which took effect October 1, 1984, bases a hospital's allowance for charity care and bad debts on a three-year historical average.

### Summary

In this overview of state programs providing assistance to the medically indigent, a few observations can be made. First, the lack of federal involvement and guidance -- both in program administration and financing -- has resulted in a great variation in the approaches states have taken in assisting the medically indigent. This freedom has permitted states to be creative in developing programs and policies that are appropriate to the state's demographic, economic, and political characteristics. States can, and do, adopt programs that target their aid toward specific population groups they believe to be particularly vulnerable.

Second, the broad range of programs and the substantial state and county funding provided to finance such programs indicate the substantial commitment many states make in assisting the medically indigent. Although the state and federally financed Medicaid program is the single most important program assisting low-income persons in obtaining medical care, the state indigent care programs play a key role in helping those indigents not eligible for Medicaid in obtaining necessary medical care.

Finally, state interest in assisting the medically indigent is not waning, but it is changing. Previously, during better

economic times, states were enacting initiatives (such as catastrophic illness or the assumption of greater responsibility for county indigent care programs) that reduced financial barriers to necessary medical care. Today states are attempting to minimize reductions in public and private commitments to indigent care. For indigent care programs, they are trying to reduce costs through reforms in reimbursement and service delivery. And they are trying to keep charity care commitments by the private sector from being substantially reduced.

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FOOTNOTES

<sup>1</sup> Robert M. Clinkscale, Sally McCue, Ellie Weinberger, Portia De Filippes, and Maureen Fisher, Analysis of State Medicaid Programs' Characteristics, 1983, U.S. Department of Health and Human Services, Health Care Financing Administration, 1983, p.48.

<sup>2</sup> For a detailed discussion of state statutory and constitutional requirements, see Pat Butler's paper "Legal Obligations of State and Local Governments for Indigent Health Care," from Access to Care for the Medically Indigent: A Resource Document, Academy for State and Local Government, Washington, D.C. March 30, 1985, pp.13-44.

<sup>3</sup> Mark Worthington, Denise Madigan, Deborah Kuhn, and Marilyn P. Rymer Characteristics of General Assistance Programs Urban Systems Research and Engineering, Inc. Cambridge, Massachusetts, May 1983.

<sup>4</sup> Pat Butler, "Legal Obligations", p.19.

<sup>5</sup> Martin Tolchin, "As Companies Buy Hospitals Treatment of Poor Is Debated", New York Times, January 25, 1985, p.1; Margaret Engel, "Hospitals Refusing to Admit Poor", Washington Post, October 15, 1984, p.1; and "Hospitals in Cost Squeeze 'Dump' More Patients Who Can't Pay Bills, Wall Street Journal, March 8, 1985, p.33.

<sup>6</sup> National Conference of State Legislators and the Foundation for State Legislators, 12 Questions: What legislators Need to Know About Uncompensated Hospital Care: : Washington, D.C., 1984.

<sup>7</sup> E. Richard Brown, "Public Hospitals on the Brink: Their Problems and Their Options", Journal of Health Politics, Policy and Law, Vol.7, No.4, Winter 1983, p.927.

<sup>8</sup> Ibid., p.931.

<sup>9</sup> National Conference, 12 Questions.

<sup>10</sup> Frank A. Sloan, Joseph Valvona, and Ross Mullner,



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Identifying the Issues: A Statistical Profile, A paper presented at a conference entitled, "Uncompensated Hospital Care: Defining Rights and Assigning Responsibilities", Vanderbilt University, April 6-7, 1984, p.19; and "Public Hospital Limits Care to Tampa's Poor", AMA News, April 20, 1984, p.21.

<sup>11</sup> David R. Riemer, Wisconsin's Uninsured: The Scope of the Problem and Alternative Solutions, Milwaukee, Wisconsin, December 24, 1984, p.24; and David L. Kennel and John F. Sheils, Analysis of Health Care Utilization and Expenditures in Minnesota for 1985, Minnesota Health Planning Agency, November 1984, p.110.

<sup>12</sup> National Health Law Program, Uncompensated Care under Prospective Hospital Reimbursement Systems, May 11, 1984.



## **CHAPTER IV**

### **STATE PROGRAMS OF ASSISTANCE FOR THE MEDICALLY INDIGENT**

*Part A: Explanation of State Profile and Terms*

*Part B: List of Programs in State Profiles*

*Part C: State Profiles*





## ***PART A: EXPLANATION OF STATE PROFILE AND TERMS***

### **Collection of Program Information**

The information describing each state's indigent care program reflects the policies in effect during June 1984 except for Arkansas, Nevada, Oklahoma and Texas which reflects the legislation adopted but not yet implemented.

The information describing each state's indigent care program was developed in the following manner. IHPP abstracted key information from the files it has amassed on indigent care programs over the years. Other published materials were used to update the IHPP files and to fill in gaps of missing information.

Information on the programs' benefits coverage, eligibility standards, reimbursement methodology, expenditure figures, and other data was abstracted and forwarded to the state agency that administered the Title XIX-Medicaid program in the belief that the agency administering the Title XIX-Medicaid program is most likely to be aware of a state program for the medically indigent if the agency does not administer such a program itself. Depending on the state, however, the ultimate respondent providing information on a state's program for the medically indigent (or lack of such a program) may have been another state agency. Frequently, legislative support staff verified particular components of the program data, usually program expenditure figures. Nonresponses were followed up with phone inquiries. IHPP was able to gather information on all 50 states and the District of Columbia. Each state was requested to review the IHPP data on its state program for the medically indigent and update it with recently adopted policy changes. IHPP reviewed the information and made followup phone calls when necessary to clarify responses.

A word of caution is necessary about specific information in the profiles. This information is often self-reported; that is, the state interpreted what IHPP requested and responded accordingly. Although IHPP had included specific instructions and definitions to direct the agency toward the type of information needed, specific entries for each state's profile vary in completeness.

This variation reflects any one of three reasons. First, a state's policy in an area (reimbursement methodology, or

eligibility standards, for example) may be defined in very simple terms, while other states may have extensive rules and regulations. Second, states whose program for the medically indigent were of recent interest to state policymakers -- usually due to major increases in expenditures -- frequently had published reports or background papers describing the program's policies. In these states, IHPP not only had better background information on the program but also found that a greater number of state workers were knowledgeable about the program or knew where to direct IHPP's inquiries.

Last, because the states were not subject to uniform reporting requirements at the federal level -- as is required under the state and federally funded Title XIX-Medicaid program -- the data are not always uniform from state to state. This problem was most apparent in two entries -- expenditures and recipients. Not all states had expenditure data available for all fiscal years requested. Another problem is that not all states use the same fiscal year. Some run from October 1st through September 30, others from July 1 through June 30. Other programs report data by calendar year. IHPP relied on the states to designate the fiscal year in which expenditures occurred. Certainly refinement of the raw IHPP data is possible; however, getting an exact figure for all states that reflects the expenditures incurred in a uniformly defined 12-month period is impossible. At best a refined estimate can be made.

The other information not uniformly reported is the number of recipients receiving services under the state program for the medically indigent. The preferred figure reflects the total number of different recipients served by the program, which is called an "unduplicated count" (see data entry explanations below). In those states where the state program is administered by the same agency administering the Title XIX-Medicaid program, unduplicated counts are frequently available, for the agency is able to use existing claims-processing methods and sophisticated computer programming to arrive at such a figure. Other states collect the total number of recipient encounters (called a "duplicated count"), some refer to the total number of eligibles (which overestimates the recipient count because not all eligibles use the services covered), and some refer to total patient days.

### **Programs Described**

The programs described under "State Indigent Care Programs" are limited to those state- and county-funded (or a combination of both) programs established to provide medical care to the indigent or medically indigent. Programs that used any federal funding (Title XIX-Medicaid, home- or community-based services financed by Title XIX, and maternal and child health programs that rely on block grant funding) are specifically excluded from the profile.



IHPP did not collect information on programs that were county or regional in scope. Such programs are very important, especially in major metropolitan areas. To include all such locally based programs would have been impossible, however. Exceptions to this rule have been made to demonstrate the variety of approaches in providing necessary medical care to the indigent. The state programs described in Alabama, Florida, Nevada, and South Dakota are locally based programs that have been created under state statutory authority.

Another type of locally based program for the medically indigent is the interhospital agreement. Kentucky's intergovernmental agreement with Humana Incorporated, which provides funding for charity care at a hospital in Louisville, is described under "Limited State Indigent Care Programs." Columbia, South Carolina has an interhospital agreement that shares funding for charity care provided at any of four hospitals located in Richland and Lexington counties. Participants view the latter agreement as a short-term solution. These types of agreements are becoming more common, especially when the sale or leasing of a government hospital to a private company is involved.

Attempts were made to include those states that provide funds to hospitals for financing charity care. Such payments are usually directed to the state university teaching hospital that is used by the medical school faculty. Unfortunately, IHPP had little confidence in the figures provided (most respondents were quite explicit about their discomfort over possible misinterpretation of the data), and the figures consequently are not included in the state's profile. Some states appropriated funds to state university hospitals to cover some of the costs of providing charity care, but there often was no required documentation to verify that the funds were specifically spent on charity care. In other states, one of the founding principles of establishing a university hospital and medical school was based on a sometimes implicit, other times explicit, quid pro quo. In return for receiving state funding that supported teaching and operational costs of the medical school and hospital, the hospital agreed not to turn any patient away.

The guiding principle on whether to include a state program for the medically indigent was whether the funding level was directly related to the utilization level. That is, when utilization increased (or unit costs increased), then the funding increased. Or conversely, if a maximum funding level was established, then the amount of utilization that could be reimbursed was limited. An example of the former is the state funding of charity care provided at Medical College of Virginia and the University of Virginia Hospital. Examples of the latter are the University of Colorado and the University of Iowa, described under their respective states.

The description of the entries and terms used in each state's profile of state programs for the medically indigent is organized in the following manner:

## STATE'S NAME

- I State Indigent Care Programs
- II Limited State Indigent Care Programs
- III Indigent Care Provisions under Rate Setting
- IV Health Insurance Alternatives
- V Certificate of Need Provisions Affecting Indigent Care

## STATE'S NAME

If a state has more than one program for the medically indigent, all are briefly summarized and assigned a listing of A, B, etc. Accordingly, program A is fully described before B is described.

### I. State Indigent Care Programs

#### A. Title of State Indigent Care Program

The title of the state's program for the medically indigent is listed next to A. Some states designate their program with specific name (Kansas's Medikan, Michigan's Resident County Hospital Program), while other states identify their program as a component of a larger one (hence, Pennsylvania's program for the medically indigent is a component of the General Assistance program).



Quite often the program is designated by statute as the payor of last resort, which means all attempts to collect payments from private insurers, Medicare, Medicaid, or other programs must be made before the state program will reimburse for services.

### 1) Eligibility Standards

States were asked to provide very basic information on their eligibility standards. Most states have income maximums based on family size. Unfortunately, the definition of terms varies by state. Some states define income with the current month, others use the average of the past 3 months, and some use a 2-month projection. Some states allow specific items to be excluded in determining income; others allow none. And, it is important to note that specific state eligibility standards for a program may exceed 10 pages. Consequently, any summary of eligibility standards runs the risk of oversimplification. Thus, while any researcher should be hesitant about using the data for any particular state, the overall 50-state data should be viewed as representative when taken as a whole.

#### a) Categorical

This entry notes whether medical coverage is automatically extended to recipients of another state or county program. Frequently, eligibility is extended to recipients of the general assistance program (also called general relief or home relief). General assistance programs provide various types of support that varies from cash payments to such tangible goods as bus tickets or firewood. (See Characteristics of General Assistance Programs 1982, Urban Systems Research and Engineering, Inc., May 1983.)

#### b) Income

Income maximums for an individual living alone and a family of four are listed when available.

#### c) Assets

Most eligibility criteria require applicants to make all efforts to finance their own medical care, which may mean the individual or family must finance part of the care by selling some assets and spending savings. It is common that a state will exempt (also called an exclusion) the house and one automobile from the limitations on assets.



#### d) Other

This is a catchall entry that does not appear in every state profile. Some states attach additional requirements for receiving care, such as requiring an able-bodied recipient to sign up for a workfare program. Other states extend eligibility to special categories of individuals. Those special categories are listed here.

It is of interest to note that technically many states appear to have state laws or regulations that require a minimum duration of state residency (i.e. the applicant must have been a resident of the state during the preceding 6 months). The U.S. Supreme Court has struck down such requirements.<sup>1</sup>

All state responses indicated that intent to stay is sufficient proof of residency. Nonetheless, many states restrict their program eligibility to state residents only.

#### 2) Services and Providers

If the state program for the medically indigent reimburses the same providers for the same services as the Title Medicaid program, then the entry will read "same as the categorically needy component of the Title XIX-Medicaid program."

Under the Categorically Needy component of the Title XIX-Medicaid program, the following relevant services are provided:

- Inpatient hospital services;
- Outpatient services;
- Physician services;
- Lab and x-ray services;
- Family planning services; and
- Rural health clinics.

Few states cover the other two services: skilled nursing facility and early periodic screening, detection, and treatment for children under age 21 (EPSDT). States may

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<sup>1</sup> See P. Butler, "Legal Obligations of the State and Local Governments for Indigent Health Care", Access to Care for the Medically Indigent: A Resource Document for State and Local Government, Academy of State and Local Governments, Washington D.C., March 1985.

choose to offer additional services under Title XIX-Medicaid. For a chart of state-by-state coverage under Title XIX, see Appendix B.

In most circumstances where a state covers the same services as Title XIX, no further breakdown of information is included.

a) Services Covered

The major services that are reimbursed are specifically listed when available. Some states do not have a specific list of services but defer to the physician's judgment that the service was medically necessary. University- or hospital-based programs frequently provide all services available at the teaching hospital. When available, any limitations on services, such as prior authorization or coverage only in life-threatening situations, are noted under this heading.

b) Providers and Settings

This entry lists restrictions on the settings (hospital, clinics, physician's office) where the services may be rendered for providers to be reimbursed. Under the Iowa program, only the University of Iowa Hospital and Clinics may be reimbursed. Under the California's Medically Indigent Services Program, counties may enter into sole-source contracts with hospitals. Under such a system, any care (unless an emergency) must be provided by the contracting hospital to receive reimbursement.

3) Administration

a) Responsible Entities

Responsibility for conducting three key tasks of administering any program for the medically indigent is described in this section.

"Establishes the eligibility standards" refers to responsibility for promulgating the maximum income levels and other criteria for eligibility.

"Conducts the eligibility determination" refers to the processing of specific individuals applying for the program to determine whether the applicant meets the eligibility standards.

"Processes providers' claims" refers to the task of receiving providers' bills and reimbursing them for

the services rendered.

b) Funding Source

This section indicates the percent of program expenditures financed by the state or local government.

c) Reimbursement Methodology

The response rate to this entry was rather low. Those that did respond are listed.

4) Recipient and Expenditure Data

a) Total Expenditures

States were requested to verify and update the information on the program's expenditures since state fiscal year 1980. The state designated the fiscal year the expenditures represented. (Not all states have the same fiscal year.)

Consequently, caution is urged in interpreting the expenditure data. First, when comparing expenditures between states, it must be remembered that the figures may represent a slightly different time period, although it is likely they coincide by several months. Second, the total of all state/county expenditures for any given year, is simply an estimate. Nonetheless, it should be a very good estimate of state and county expenditures for the program reported. (IHPP intends to refine and update the expenditure data on an ongoing basis.)

Obviously, states and counties spend more on programs for the medically indigent than the state profiles report. The most notable absence is state and county funding of hospitals for charity care provided in the public or teaching hospitals.

b) Recipients Served

The preferred measurement for estimating the number of recipients is the unduplicated count. Such a figure represents the number of different recipients that used services under the program for the medically indigent. Individuals admitted twice to a hospital or visiting a physician twice within the unit of time (month or year) are counted only once. The unduplicated count represents the number of recipients who received services within that month or year.



A duplicated count - which occurs frequently in the state profiles - indicates the total number of patient encounters reimbursed by the program. Therefore, if a recipient was admitted to a hospital 2 times in a year, they are both counted for that year. Furthermore, care should be given taken to ensure that the figure represents a monthly or yearly count of recipients.

Not all states reported the number of recipients treated by the program. Some states did not have the recipient counts but did have the number of individuals eligible for the program. Other states reported the total number of patient days reimbursed. IHPP did not include these latter figures in the state profile.

#### 5) Recent and Proposed Changes

States were requested to provide information on recent (since 1980) changes in the state program for the medically indigent. All responses are listed, but not all states responded. Any significant legislative changes in the 1985 session are also listed here.

### II. LIMITED STATE INDIGENT CARE PROGRAMS

In the IHPP survey, states were requested to identify and describe other state health care programs that provide a limited range of medical services to low-income persons. These limited indigent care programs--such as Wisconsin's Hemophilia program, Missouri's Blind Pension program, and New Jersey's Pharmaceutical Assistance of Aged and Disabled Persons--usually restrict service coverage to those that are curative for a given condition (potential blindness) or are palliative for a chronic condition (hemophilia).

Although IHPP attempted to make the listing of state indigent care as comprehensive as possible, there was no similar follow-up for limited programs. Therefore, the descriptions under "Limited State Indigent Care Program's" should be considered illustrative rather than exhaustive.

### III. INDIGENT CARE PROVISIONS UNDER RATE SETTING

Nine states have implemented or about to implement rate setting systems for payment of inpatient hospital services. Each of these systems operates differently, but all include some provisions for uncompensated care. Information on the rate setting systems of New Jersey, Maryland, New York, and Massachusetts

was abstracted from the National Health Law Program's paper titled, Uncompensated Care under Prospective Hospital Reimbursement Systems (May 11, 1984). IHPP collected material updating the information on the existing six rate-setting states plus material on the other three states implementing rate setting.

#### IV. Health Insurance Alternatives

Given that lack of insurance increases the likelihood of a person becoming medically indigent, several states have adopted strategies to increase the percentage of people with adequate health insurance coverage. A state's profile includes a description of its catastrophic health insurance program and comprehensive health insurance association if adopted by the state.

A few states have created catastrophic health insurance programs designed to mitigate the financial effects of a lengthy, costly illness or injury. Each state with a catastrophic health insurance program has structured its program differently, but their purpose and operation are similar. People who suffer catastrophic illnesses must exhaust their own health insurance coverage, if any, and then pay a substantial amount of the costs through some type of cost-sharing provision.

The second type of state strategy to increase the percentage of the population covered by health insurance is the adoption of comprehensive health insurance associations, more frequently called risk pools. Risk pools are designed to offer health insurance coverage to persons denied coverage by one or more insurance carriers because of poor health status. The premiums for such coverage tend to be expensive, ranging from 125 to 150 percent of those charged to standard-risk persons.

Information on risk pools and catastrophic illness programs was abstracted (and updated) from State Comprehensive and Catastrophic Health Insurance Programs: An Overview, by T. Van Ellet, Intergovernmental Health Policy Project, October 1981.

Continuation and conversion of group health insurance benefits are strategies for dealing with two different problems. Continuation allows insured individuals to maintain a current group health insurance policy for a limited period of time (usually 3 to 6 months). Continuation policies require insurers to offer workers whose health insurance policies have been terminated (usually through layoffs) the opportunity to continue their policies. Policyholders pay the entire premium but receive the benefit of group rates rather than the more expensive individual rates. Conversion statutes require insurers to permit people whose policies have been terminated to convert

their group policies to individual policies.

Information on state continuation and conversion statutes is summarized in Appendix A, and is not described in the state profiles. The material on continuation and conversion statutes is an update of State Requirements for Continuation and Conversion of Private Health Insurance Benefits, by Kathleen A. Brennan, Intergovernmental Health Policy Project, 1982.

V. Certificate of Need Provisions Affecting Indigent Care

The certificate of need program was established as a cost containment tool that is designed to help control unnecessary or inappropriate capital expenditures by hospitals and other health care providers. For those states that have a CON program, the statute basically requires hospitals and other health care facilities to obtain the state's consent before making expenditures to increase beds, replace existing facilities, purchase new equipment, or institute a major change in services.

States have some leeway in developing criteria for approving a CON proposal, and a few states have adopted provisions that link CON approval with the applicant's commitments to providing indigent or charity care. For example, South Carolina requires health care facilities to submit an indigent care plan as part of the CON approval process.

Information on certificate of need provisions affecting indigent care was based on IHPP files, The Statutes of Major State Policies Affecting Hospital Capital Investment, by IHPP, July 1984, and Major State Health Laws of 1984, by IHPP, 1984.





***PART B: LIST OF PROGRAMS IN STATE PROFILES***

The following table lists the programs included in each state's profile. This table represents the programs identified by the states as of June 1984 plus recently (1985) adopted legislation creating a state indigent care program for the states of Arkansas, South Carolina, and Texas.

All findings in the Executive Summary and Chapter III are based on these programs as they existed in June 1984. Initials in brackets indicate the shorthand notation used to identify the programs listed in the chart "Characteristics of State Indigents Care Programs." Other 1985 legislation making significant changes in state indigent care programs or indigent care policies (such as Nevada) are also included.

PROGRAMS IN THE STATE PROFILES

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State	Program	Page
Alabama	I Health Care Responsibility Act {HCRA} . . . . .	69
	II Cancer Screening And Treatment for Indigents . . . . .	71
Alaska	I General Relief Medical {GR-M} . . .	73
	IV Catastrophic Health Insurance . . .	75
Arizona	I Arizona Health Care Cost Containment System {AHCCCS} . . . .	79
Arkansas	I A. Indigent Health Care Program {1985} . . . . .	83
	B. University of Arkansas for Medical Sciences . . . . .	84
	II High-Risk Maternity Patients . . .	84
California	I A. County Medical Services Program {CMSP} . . . . .	85
	B. Medically Indigent Services Program {MISP} . . . . .	89
	V CON Indigent Care Provisions . . .	92
Colorado	I A. Statewide Medically Indigent Program {SMIP} . . . . .	93
	B. Community Maternity Program {CMP} . . . . .	97



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Connecticut	I General Assistance Medical Aid Program {GA-MA} . . . . .	101
	II Soldiers, Sailors and Marines Fund . . . . .	105
	III Indigent Care Under Rate Setting . . . . .	106
	IV Comprehensive Health Insurance and Risk Pool . . . . .	107
Delaware	I No State Program . . . . .	111
Dist. of Columbia	I Medical Charities Program {MCP} . . . . .	113
	V CON Provisions Affecting Indigent Care . . . . .	113
Florida	I Health Care Responsibility Act {HCRA} . . . . .	115
	II A. Primary Care Networks . . . . .	115
	B. Regional Perinatal Intensive Care Program . . . . .	116
	IV Risk Pool . . . . .	116
Georgia	I No State Program . . . . .	119
	V CON Indigent Care Provisions . . . . .	120
Hawaii	I State-Only Medicaid {SM} . . . . .	121
	IV Mandatory Health Insurance . . . . .	123
Idaho	I No State Program . . . . .	127
Illinois	I A. General Assistance Medical Program {GA-M} . . . . .	129
	B. Aid to the Medically Indigent {AMI} . . . . .	132
	II Pharmaceutical Assistance to the Aged and Disabled . . . . .	134

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Indiana	I Hospital Care for the Indigent {HCI} . . . . .	135
	IV Risk Pool . . . . .	137
Iowa	I State Papers Program {SP} . . . . .	139
Kansas	I MediKan {MKAN} . . . . .	141
Kentucky	I No State Program . . . . .	145
	II Quality Charity Care Trust . . . . .	145
Louisiana	I State Charity Hospital System {SCHS} . . . . .	147
Maine	I General Assistance Medical {GA-M} . . . . .	149
	II A. Medical Eye Care Program . . . . .	151
	B. Pharmaceutical Assistance for Aged persons . . . . .	151
	III Indigent Care Under Rate Setting . . . . .	151
	IV Catastrophic Health Insurance . . . . .	152
Maryland	I State-Only Medicaid {SM} . . . . .	157
	II Pharmaceutical Assistance Program . . . . .	159
	III Indigent Care under Rate Setting . . . . .	160
Massachusetts	I General Relief {GR} . . . . .	163
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Michigan	I A. Resident County Hospitaliza- tion Program {RCH} . . . . .	169
	B. General Assistance Medical {GA-M} . . . . .	171
	C. Nonresidents Hospitalization Program . . . . .	174
Minnesota	I A. General Assistance-Medical Care {GA-MC} . . . . .	175
	II University Hospital Papers Program	178
	IV A. Catastrophic Health Insurance	178
	B. Comprehensive Health Insurance and Risk Pool. . . . .	180
Mississippi	I A. State Hospital Commission {SHC}	183
	B. Charity Hospital System . . . . .	184
Missouri	I General Relief-Medical {GR-M} . . . . .	187
	II A. Blind Pension Program . . . . .	190
	B. High-Risk Maternity and Child Care Programs . . . . .	190
	C. Other Limited Indigent Care Programs . . . . .	191
Montana	I State Administered General Relief {GR} . . . . .	193
	IV Risk Pool {1985} . . . . .	195
Nebraska	I No State Program . . . . .	197
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Nevada	I A. Supplemental Fund for Assistance to Indigent Persons {1985} . . .	199
	B. Fund for Hospital Care to Indigent Persons . . . . .	200
New Hampshire	I No State Program . . . . .	201
New Jersey	I A. General Assistance-State Match Medical Program {GASMM} . . . . .	203
	B. AFDC Non Federal-Medical {AFDC-NF} . . . . .	205
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New Mexico	I Indigent Hospital Claims Act . . . . .	211
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New York	I State-Only Medicaid {SM} . . . . .	213
	III Indigent Care Under Rate Setting . .	215
North Carolina	I No State Program . . . . .	217
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	II Pharmaceutical Assistance for the Aged . . . . .	235
Rhode Island	I General Assistance-Medical {GA-M} .	237
	IV Catastrophic Health Insurance . . .	239
South Carolina	I Medically Indigent Assistance Fund {1985} . . . . .	245
	II A. Midlands Hospitals Indigent Care Partnership . . . . .	246
	B. Sickle Cell Anemia . . . . .	247
	V CON Indigent Care Provisions . . . .	248
South Dakota	I Catastrophic County Poor Relief Fund {CCPR} . . . . .	249
	II Kidney Disease Program . . . . .	250
Tennessee	I No State Program . . . . .	251
	II A. Speech and Hearing Program . . .	251
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Virginia	I A. State and Local Hospitalization Program {SLH} . . . . . B. General Relief-Ongoing Medical Assistance {GR-ON} . . . . . C. General Relief-Emergency Medical Assistance {GR-ER} . . . D. State Teaching Hospitals {STH} .	263 266 268 270
Washington	I A. General Assistance-Unemploy- able Program {GA-U} . . . . . B. Limited Casualty Program- Medically Indigent {LCP-MI} . . . III Indigent Care Under Rate Setting . .	273 276 279
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Wisconsin	I A. General Relief-Medical {GR-M} . . II A. Chronic Renal Disease Program . . B. Hemophilia Program . . . . . C. Needy Indians Program . . . . . III Indigent Care Under Rate Setting . . IV Risk Pool . . . . .	283 285 285 285 286 286
Wyoming	I Minimum Medical Program {MMP} . . .	291







### The Characteristics of State Indigent Care Programs

The following chart summarizes the key characteristics of the state indigent care programs. Because each state program is in many respects unique, it is important to know how the chart was constructed and programs categorized.

The chart lists only those programs defined as state indigent care programs that are described under Section I of a state's profile. It is the purpose of this report to document these programs on a systematic basis. The appearance of program initials under column 2 does not necessarily indicate a state indigent care program, it may simply indicate the state has a statute delineating requirements for county programs such as Alabama's Health Care Responsibility Act (HCRA), Indiana's Hospital Care Indigent Program (HCIP), New Mexico's Indigent Hospital Claims Act (IHCA) and South Dakota's County Catastrophic Poor Relief Fund (CCPR).

Only the following 34 states had State Indigent Care programs:

#### States with State Indigent Care Programs

Alaska	Maryland	Pennsylvania
Arkansas	Massachusetts	Rhode Island
Arizona	Michigan	South Carolina
California	Minnesota	Texas
Colorado	Mississippi	Utah
Connecticut	Missouri	Virginia
Hawaii	Montana	Vermont
Illinois	New Jersey	Washington
Iowa	New York	Wisconsin
Kansas	Ohio	Wyoming
Louisiana	Oklahoma	{District of Columbia}
Maine	Oregon	

It is important that the reader understand that the other 16 states may have indigent care programs that are either limited to specific regions of the state -- see Kentucky's Quality Care Trust Fund-- or are totally funded and administered by the counties-- see Indiana's Hospital Care for the Indigent Program. The reader is urged to use the chart as a quick reference only; one should always double-check the state's profile for clarification. Of the 34 states with State Indigent Care Programs, 30 had operational programs as of October 1985. The four states that did not were Arkansas, Oklahoma, South Carolina, and Texas.



## Characteristics of STATE INDIGENT CARE PROGRAMS

State	Program	Administrative Responsibility	Benefit/ Eligibility Standards	Sets Eligibility Standards	Benefits	Source of Funding	FY-83 Expenditures (millions)	Explanatory Notes
AL	HCRA†	county	nonuniform	state/county	IP hospital	county	—	
AK	GR-M	state	uniform	state	similar to Title XIX	state	\$8.7	
AZ	AHCCCS	state	uniform	state	similar to Title XIX (no SNF)	state/county	—	
AR	IHC	state	uniform	state	hospital/ambulatory	state	—	1985 act
CA	CMSP MISP	state county	nonuniform nonuniform	state county	similar to Title XIX (no SNF) varies; most counties similar to Title XIX	state state/county	\$35.5 \$440.4	option to small counties only state only
CO	SMIP CMP	state state	uniform uniform	state state	basic coverage IP and OP hospital (limited home health)	state state	\$33.3 \$1.8	component of SMIP
CT	GA-MA	state/town	uniform	state	similar to Title XIX	state/town	\$14.7	
DE	none	county	nonuniform	county	varies by county	county	—	
DC	MCP	state	uniform	state	IP and OP hospital	state	\$1.7	
FL	HCRA†	county	nonuniform	county	IP hospital	county	—	
GA	none	county	nonuniform	county	varies by county	county	—	
HI	SM	state	uniform	state	same as Title XIX	state	\$27.5	
ID	none	county	nonuniform	county	varies by county	county	—	
IL	GA-M AMI	state/county state	nonuniform uniform	state state	basic coverage basic coverage	state/county state	\$84.1 \$50.4	
IN	HCI†	county	nonuniform	state	IP and OP hospital (emergency only)	county	—	
IA	SP*	state/county	nonuniform	county	all services offered by U. of Iowa Hospital and Clinics	state	\$24.7	
KS	MKAN	state	uniform	state	similar to Title XIX	state	\$25.9	
KY	none	county	nonuniform	county	varies by county	county	—	
LA	SCHS	state	uniform	state	IP and OP at Charity Hospital	state	\$157.0	
ME	GA-M	state/county	nonuniform	state/county	medically necessary (determined by physician)	state/county	\$0.4	
MD	SM	state	uniform	state	same as Title XIX	state	\$93.5	
MA	GR	state	uniform	state	physician and ambulatory services	state	\$7.2	
MI	RCH* GA-M	state/county state	nonuniform uniform	county state	IP hospital physician and ambulatory services	state/county state	\$49.5 \$18.2	
MN	GA-MC	state/county	uniform	state	basic coverage	state/county	\$32.2	
MS	SHC	state	nonuniform	hospital	IP hospital	state	\$2.3	1984 expenditure
MO	GR-M	state	uniform	state	similar to Title XIX	state	\$14.7	
MT	GR*	state/county	nonuniform	state/county	same as Title XIX	state/county	\$4.4	
NE	none	county	nonuniform	county	varies by county	county	—	
NV	SFAIP†	state	nonuniform	county	IP hospital	county	—	1985 act
NH	none	county	nonuniform	county	varies by county	county	—	
NJ	GASMM* AFDC-NF	state/town state	uniform uniform	state state	similar to Title XIX same as Title XIX	state/town state	\$17.5 \$4.1	
NM	IHCA†	county	nonuniform	county	IP hospital	county	—	
NY	SM	state/county	uniform	state	same as Title XIX	state/county	\$533.5	calendar year
NC	none	county	nonuniform	county	varies by county	county	—	
ND	none	county	nonuniform	county	varies by county	county	—	
OH	GR-M	state/county	nonuniform	state	IP and OP hospital, physician	state/county	\$130.7	
OK	IHC*	state/county	nonuniform	state	hospital	state/county	—	not implemented as of 10/85
OR	GA-M	state	uniform	state	same as Title XIX (more restrictive IP hospital)	state	\$13.6	
PA	GA-M	state	uniform	state	same as Title XIX (some additional limits)	state	\$356.6	
RI	GA-M*	state/town	uniform	state	same as Title XIX	state	\$10.2	
SC	MIAF	state	uniform	state	IP hospital	county/hosp.	—	1985 act
SD	CCPR†	state/county	nonuniform	state	county catastrophic medical expenses	county	—	
TN	none	county	nonuniform	county	varies by county	county	—	
TX	IHCT	state/county	nonuniform	state	similar to Title XIX (\$30,000 limit)	state	—	1985 act
UT	IMAP*	state	nonuniform	state	basic coverage	state/county	\$2.9	
VT	GA-M	state	uniform	state	physician and limited ambulatory	state	—	
VA	SLH* GR-ON* GR-ER* STH	state/county state/county state/county state	nonuniform nonuniform nonuniform nonuniform	county state/county county state	IP and OP hospital physician and ambulatory, but varies by county physician and ambulatory, but varies by county IP and OP hospital	state/county state/county state/county state	\$8.2 \$0.6 \$0.1 \$50.3	estimate

State	Program	Administrative Responsibility	Benefit/Eligibility Standards	Sets Eligibility Standards	Benefits	Source of Funding	FY-83 Expenditures (millions)	Explanatory Notes
WA	GA-U LCP-MI	state state	uniform uniform	state state	same as Title XIX (except no dental) basic coverage	state state	\$37.3 \$13.6	
WV	none	county	nonuniform	county	varies by county	county	—	
WI	GR-M	state/county	nonuniform	county	varies by county	state/county	\$2.5	state only
WY	MMP	state/county	nonuniform	state	similar to Title XIX, varies by county	state	\$2.1	estimate
						total	\$2,311.0	estimate

## CHART KEY and NOTES

### Explanation

Column 1, *State*.

Column 2, *Program*, designates the initials of the state indigent care programs or the initials of the guiding state statute. See the list of programs in the state profiles in Chapter IV, Part B, for the full program name or title of the state statute.

† The symbol † in Column 2 indicates that the program or statute summarized is *not* a state indigent care program. The entry is a state statute delineating county responsibilities.

\* An *asterisk* in Column 2 indicates that the program is an optional state program. That is, the local entity legally responsible for providing care to resident indigents has the option of participating in the program. The inducement for cities or counties to participate is usually some form of state assistance—administrative, financial or both.

Column 3, *Administrative Responsibility*, indicates which governmental entity—state, counties, towns, or a combination—has overall responsibility for administering the program.

Column 4, *Eligibility Standards*, indicates whether the program benefits and eligibility standards are uniform across county lines or vary from county to county such that the benefits and standards are nonuniform.

Column 5, *Sets Eligibility Standards*, indicates which entity, the state, county, or hospital establishes the eligibility standards.

Column 6, *Benefits*, summarizes the type of services covered under the state indigent care program. For those states that have statutory guidelines for county indigent care programs (noted by †), the column indicates the minimum benefit coverage.

Given the discretion states have in determining benefit coverage, the categories used for describing a program's coverage should be viewed as generalizations. Although some states offer a similar benefit coverage, none have identical, benefit coverage. Under the categorically needy component of the Title XIX Medicaid program the following services are mandatory: inpatient and outpatient hospital, physician, labs and X-ray, skilled nursing facility and home health, rural health clinic, family planning and early periodic screening, detection, and treatment (EPSDT). (See Appendix B, State Medicaid Characteristics chart.) The categories are listed in ascending order; that is, the breadth and depth of the benefit coverage increases with each category.

*Varies by county* indicates each county sets the benefit coverage and therefore benefit coverage varies within the state.

Listed benefits indicates only those services that are covered. *IP*, *OP hospital* indicates inpatient and outpatient services provided at the hospital. *Ambulatory* indicates physician and other noninstitutional settings for primary care.

*Basic coverage* indicates the program covers most of the mandatory services under the categorically needy component of Medicaid. Unless noted, this designation does not include EPSDT for children or skilled nursing facilities.

*Similar to Title XIX* indicates the state indigent care program covers virtually the same services as the state's Medicaid program. (See Appendix B for state benefit options under Title XIX.) The difference is the indigent care program usually has more restrictive limitations, does not cover nursing home services, or covers slightly fewer services.

*Same as Title XIX* indicates the indigent care program benefits are identical to the state's Medicaid program. However, since each state's program is different, the benefits covered under this designation vary with the state.

Column 7, *Source of Funding*, indicates which governmental entity funds the program: state, county, town or a combination of them. South Carolina's program is funded by assessments on counties and hospital revenues.

Column 8, *FY-83 Expenditures* are the program expenditures (in \$millions) for state fiscal year 1983. All states use July 1 through June 30 for their fiscal year except: Michigan and Alabama (October 1-September 30); New York (April 1-March 31); and Texas (September 1-August 31).

Column 9, *Explanatory Notes*, are as follows:

1985 Act:	Denotes that the statute was enacted in 1985 and was not implemented as of 10/1/85.
State only:	Indicates that the expenditures in Column 7 reflect only the state's portion of the state/county program expenditures.
1984 expend:	Mississippi's expenditures for fiscal year 1983 were unavailable.
Calendar year:	New York's expenditures are not available by fiscal year.
Estimate:	State was only able to estimate the expenditures.





### PART C: STATE PROFILES

Part C of Chapter IV contains the heart of the report: a profile of each state's (plus the District of Columbia) indigent care programs and policies identified from IHPP files, or abstracted from a national publication (see Part A for methods and sources). No state profile has entries in each section:

- I State Indigent Care Programs
- II Limited State Indigent Care Programs
- III Indigent Care Provisions under Rate Setting
- IV Health Insurance Alternatives
- V Certificate of Need Provisions Affecting Indigent Care

Therefore the reader should not be worried if a state's profile jumps from Section I to Section III or V: it either indicates the state does not have such a program or policy in effect; or in the case of Section II, Limited State Indigent Care Programs, many states did not identify such programs although there is a high likelihood one does exist.



# ALABAMA

## I. STATE INDIGENT CARE PROGRAMS

### A. Health Care Responsibility Act

Health Care Responsibility Act (Act 808 of 1979); places ultimate financial responsibility for medical treatment of the indigent on the county in which the indigent resides. The act also establishes the indigent's county of residence as financially responsible for medical care received at regional referral hospitals when such counties lack facilities offering services.

The program governing reimbursement to regional referral hospitals is essentially nonfunctioning, and a legislative committee is examining funding alternatives.

The following information refers to the regional referral component of the Alabama Health Care Responsibility Act.

#### 1) Eligibility Standards

An indigent is a person who is acutely ill or injured and can be helped markedly by treatment in a hospital but cannot afford such treatment. Any individual who has received any Medicaid benefits within the last year is ineligible for hospitalization.

The State Department of Pensions and Security has proposed eligibility criteria; a county is permitted to establish less restrictive income standards but may not adopt more restrictive standards.

#### a) Categorical

None



b) Income

Individual ..... \$283/month  
Family of 4 ..... \$558/month

A county may establish less restrictive income standards but may not adopt more restrictive standards.

c) Assets

Resources cannot exceed \$1,750, excluding a homestead that cannot exceed 160 acres.

## 2) Services and Providers

Counties are required to reimburse regional referral hospitals for hospitalization services provided to indigents residing in their county. No other services are provided. Coverage is limited to the lesser of 30 days per year or the number of days allowed under Medicaid (currently 12 days per year). Prior authorization is required, except in emergency situations.

The county is not responsible for reimbursing regional referral hospitals when services rendered are available at a local hospital in the county where the indigent resides (except in emergency situations).

## 3) Administration

a) Responsible Entities

The act states that the County Board of Commissioners shall designate a person to perform the eligibility certification, or, in the absence of such a designated person, the County Health Officer shall perform the certification duties.

b) Funding Source

Funding is totally from county revenues, with the state constitution permitting the levying of special county taxes for hospital care provided to resident indigents. This provision includes care provided at the hospital as well as care provided at a regional referral center. No county is required to pay until all-third party payers have paid their share of medical treatment costs.

c) Reimbursement Methodology

Reimbursements to the regional referral hospitals is the same as the Medicaid rate, which is a prospective payment system.

4) Recipient and Expenditure Data

No data available

II. LIMITED STATE INDIGENT CARE PROGRAMS

A. Cancer Screening and Treatment for Indigents

Alabama enacted a law in 1949 requiring cancer screening and treatment for indigents. The program currently operates only as a screening program for indigent women in 53 of Alabama's 67 counties. Pap smears and breast examinations are offered to approximately 15,000 to 20,000 women per year, an indeterminate number of whom are indigent. Funding for the program was \$293,000 in FY 1983, \$379,700 in FY 1984, and \$375,000 in FY 1985 (estimated).





# ALASKA

## I. STATE INDIGENT CARE PROGRAMS

### A. General Relief Medical

Alaska's General Relief program has two components: General Relief cash assistance to cover the costs of such basic needs as shelter, utilities, food, clothing, and transportation during times of extreme financial crisis; and General Relief Medical (GR-M) assistance for individuals suffering an extreme financial crisis, resulting from incurred or anticipated large medical expenses.

#### 1) Eligibility Standards

##### a) Categorical

Although the eligibility standards for the General Relief Assistance (GR-A) program and the General Relief Medical program are the same, a recipient of GR-A is not automatically extended (GR-M) coverage. The recipient must specifically apply for GR-M to receive services under the program.

##### b) Income

Individual .....	\$300/month
Family of 4 .....	\$450/month

##### c) Assets

The household cannot have more than \$500 in cash, savings, stocks, or bonds but is allowed to possess: home and land that they occupy; property that is producing reasonable income; property that is for sale at a fair market value; and property essential to employment.

## 2) Services and Providers

### a) Services Covered

The GR-M program provides the same services as the categorically needy component of the Title XIX Medicaid program, although GR-M provides pharmacy services. Drugs are not a benefit under Medicaid so Medical recipients must apply for GR-M to receive drug coverage.

All services, except inpatient hospital and inpatient physician services, are subject to prior authorization.

### b) Providers and Settings

Providers must participate in the Title XIX Medicaid program to receive GRM payment.

## 3) Administration

### a) Responsible Entities

The state establishes the eligibility standards, conducts the eligibility determination, and processes providers' claims.

### b) Funding Source

The GRM program is 100% funded by the state.

### c) Reimbursement Methodology

Hospitals and nursing homes are reimbursed on a prospective basis, physicians and dentists are paid at the 75th percentile of the usual and customary charges, and durable medical equipment is determined by the maximum charge set by the state bidding process.

## 4) Recipient and Expenditure Data

a) Total Expenditures

## General Relief Medical Expenditures

Service	FY 80	FY 81	FY 82	FY 83	FY 84*
Hospital	\$ 4.8	\$ 5.3	\$ 5.4	\$ 4.7	\$ 5.4
Physicians	2.0	2.3	2.3	1.4	1.5
Nursing homes	0.2	0.4	0.6	0.4	0.4
Other	1.8	2.3	2.5	2.2	2.6
Total	\$ 8.8	\$10.3	\$10.8	\$ 8.7	\$ 9.9

\*1984 figures are projections

b) Recipients Served

## GR-M Recipients\*

Program	FY 81	FY 82	FY 83
GRM	894	831	616

\* Figures are the average number of recipients per month. These figures do not include Medicaid recipients who receive pharmacy services under the GRM program. The number of such Medicaid recipients is approximately 2,000 per month.

## 5) Recent and Proposed Changes

In 1982, the legislature moved coverage for certain low-income children not eligible for AFDC from GRM to Title XIX Medicaid.

## IV. HEALTH INSURANCE ALTERNATIVES

A. Catastrophic Health Insurance

In 1976, Alaska enacted a catastrophic health insurance program



designed to protect average income-families and individuals from financial disaster resulting from catastrophic illnesses. The program was revised in 1978; further revisions are currently being considered because appropriations are insufficient to cover medical expenses of eligible individuals.

### 1) Eligibility

To be eligible for participation in the catastrophic illness program, applicants must meet state residency requirements, must not be institutionalized in a state facility, and must have medical expenses eligible for payment by the program. According to an analysis of the program, "... it is not targeted at low income families, as low income individuals' medical needs are provided free of charge by other state and federal programs, including the General Relief Medical program and Medicaid." Data indicate that the median family gross income of people participating in the program in FY 1984 was \$12,908. The average family size of participating persons was three, and 60% of applications in that year came from two-parent families.

Eligible applicants are required to pay part of their medical expenses not covered by third-party insurers, and the program makes payment only for unpaid expenses. It does not reimburse participants for money borrowed from other sources to pay medical debts. Applicants are required to sign agreements requiring them to pay their portion of expenses over a three-year period, and medical providers must agree to the payment plan if they wish to receive state payments.

Until June 1983, applicants' shares of expenses were determined by a formula that considered income, family size, and liquid and nonliquid assets.

The formula is:

$$\text{Applicant's share} = (40\% \text{ of adjusted gross annual income}) + \\ (\text{value of liquid resources} - \$1,000) + \\ (10\% \text{ of value of nonliquid resources})$$

where: Adjusted gross income = gross annual income - 20%, with an additional \$1,000 subtracted for each dependent.

In 1983, additional provisions were added; applicants must now pay a minimum of \$5,000, except in cases of pregnancy and childbirth, where they must pay a minimum of \$7,500. This change was made to reduce the program expenditures and to assure that program funds are used for catastrophic rather than routine medical expenses. (The pregnancy-related provision was not actually implemented until 1984.) The state will not pay unpaid medical bills until incurred expenses exceed an applicant's share. In addition, the program contains an

incentive for people to purchase private health insurance. Applicants' shares are directly reduced by the amount of private health insurance premiums paid up to a maximum of \$500.

### Covered Services

The program covers most health care services, except those specifically excluded by statute, such as elective medical or surgical procedures, experimental procedures, dentistry and optometry, drugs and medications not prescribed by a licensed physician, normal pregnancy and delivery services, private psychological or psychiatric treatment or private alcoholism services, and residential care in a skilled nursing home for more than 30 days.

### Experience

In FY 1984, applicants' median shares were between \$5,000 and \$6,000, while the state's median share was \$6,593. That year, the state served 103 cases whose expenses were less than \$10,000 and 3 cases whose expenses exceeded \$100,000. Over time, program analysts have noticed a trend toward higher program costs for high-technology care, especially in the areas of cardiovascular disease and neonatal care.

From the program's inception until FY 1981, funds appropriated were sufficient to cover program expenditures. Since FY 1982, however, appropriations have been insufficient and either supplemental appropriations or holding over approved applications until the next fiscal year has been required. The table below shows program appropriations, supplemental appropriations, and transfer of funds to the program for fiscal years 1977 to 1985.

### Catastrophic Health Insurance Appropriations

Fiscal Year	Appropriation
1977	\$300,000
1978	\$450,000
1979	\$801,800
1980	\$754,200
1981	\$977,300
1982	
1983	\$2,100,000
1984	\$2,300,000
1985	\$2,300,000

The number of people served by the program has also grown dramatically. In 1977, only 18 applications were approved. In 1980, 90 applications were approved, and in FY 1984, 165

applications of 455 submitted received final approval.

Program officials expect demand for the program to grow and FY 1986 funds (excluding the supplemental appropriation) to be exhausted before the fiscal year's end. Therefore, they are considering several options designed to control expenditures, including:

- establishing an upper limit for each individual assisted, instead of continuing the open-ended formula that permits the expenditure of several hundred thousand dollars on behalf of one person;
- continuing to raise applicants' minimum shares by altering the formula to increase the percentage of gross annual income or nonliquid resources included in applicants' shares;
- continuing the program until funds are depleted and then suspending the program until the beginning of the next fiscal year;
- limiting the number of covered medical services; and
- requiring that low-income applicants be given longer than 3 years to fulfill their payment obligations.

Consideration of these options indicates that program officials and the legislature are still trying to determine the program's goals - whether the program should:

- offer full financial assistance to a relatively small number of persons who suffer catastrophic illnesses;
- offer limited support to a larger group of people whose medical expenses, although perhaps not catastrophic in nature, exceed their ability to absorb them; or
- offer financial assistance to persons who do not qualify for other types of medical assistance, but who are unable to pay their medical expenses because of unemployment or underemployment, lack of insurance, or insufficient medical insurance.



# ARIZONA

## I. STATE INDIGENT CARE PROGRAMS

### A. Arizona Health Care Cost Containment System

Arizona was at one time the only state not to establish a Title XIX Medicaid program. Responsibility for providing medical care to the indigent rested with the counties. In 1981, Arizona's 14 counties faced a fiscal crisis. County indigent medical care costs were \$59 million in 1975, but by 1980 the costs had doubled to \$123 million. The latter amount represented one-fourth of all county revenues. Furthermore, enactment of local tax limitations restricted the counties' ability to raise additional revenues.

In November 1981, the legislature enacted a law creating a Title XIX Medicaid program, called the Arizona Health Care Cost Containment System (AHCCCS). AHCCCS is a result of Arizona's desire to establish an indigent care program that emphasizes the competitive market and uses a prepaid, capitated delivery system.

To receive federal Title XIX funds under AHCCCS, the state had to receive federal approval to waive certain Title XIX regulations. Under the authority of Section 1115 of the Social Security Act, AHCCCS was granted status as a three-year demonstration project, ending in 1985. Some of the major waivers include exclusion from coverage of long-term and home health care; mandatory copayments for all AHCCCS members; and limited freedom to choose providers. Arizona is applying for a two-year extension of its section 1115 waivers to continue the AHCCCS program through September 30, 1987.

Under AHCCCS, the state indigent component financed by state and county funds is one of the many potential membership groups. Other groups include SSI and AFDC recipients (mandatory Title XIX Medicaid recipients), at the state's option state employees (not implemented to date), county employees, and employees in the private sector.

Briefly, AHCCCS functions in the following manner. To qualify

for AHCCCS reimbursement, providers must participate in a statewide bidding process. The state prefers bidders that provide the full range of services covered under the program, although bidders are permitted to subcontract if unable to directly provide all services themselves. Each county had at least one provider (the bidder who is awarded the contract) and larger counties normally have two or more. Reimbursement is pre-paid, on a capitated basis (as agreed on in the bidder's contract) at the beginning of each month.

AHCCCS members are limited to receiving services from the contractors that have been awarded contracts in their county of residence. Other nonparticipating providers may receive payment under emergency conditions only. Members must select a primary care physician, who serves as a case manager. The primary care manager serves as a gatekeeper for AHCCCS, with any hospital admission or referrals to specialties requiring the manager's authorization.

The information in Arizona's profile describes the state/county indigent care component of the AHCCCS program. These individuals are not eligible for the Title XIX Medicaid component of AHCCCS.

#### 1) Eligibility Standards

##### a) Categorical

General Assistance recipients are not automatically eligible. They must meet the state eligibility standards.

##### b) Income

Individuals ..... \$2,500/year  
Family of 2 ..... \$3,325/year  
(with an additional 17% adjustment on the limit per additional dependent)

##### c) Assets

Households ..... \$30,000  
(of which no more than \$5,000 may be liquid assets.)

##### d) Other

Counties may expand the eligibility criteria however, financing the additional costs resulting from the expansion is the responsibility of the county.

## 2) Services and Providers

### a) Services Covered

The services covered are the same as the categorically needy component in most states; however, AHCCCS specifically does not cover long-term care (such as a nursing home or home health care). These services continue to be a responsibility of the county government.

### b) Providers and Settings

Only providers awarded a contract through competitive bidding may receive reimbursement. Between the effective date of eligibility and the date of plan enrollment, AHCCCS will cover care on a fee-for-services basis. Retroactive coverage, when applicable, is also reimbursed on a fee-for-service basis.

## 3) Administration

### a) Responsible Entities

The state establishes the eligibility standards and processes providers' claims. The county conducts the eligibility determination. The county may expand eligibility standards but must finance all costs resulting from such an expansion.

### b) Funding Source

For financing the medically indigent component of AHCCCS, the enabling legislation specified a timetable and the process. For fiscal year 1982-83, the county was required to provide an amount equal to 40% of the amount it budgeted or expended (whichever was less) for medical care for its county indigent in fiscal year 1980-81, the last year of total county responsibility before AHCCCS. The percentage increased to 50% in fiscal year 1983-84 and is subsequently indexed by increases in the GNP price deflator on an annual basis.

### c) Reimbursement Methodology

Providers awarded contracts are paid monthly, on a capitated basis. The specific amount varies by contract. Fee-for-service payments are processed biweekly.



#### 4) Recipient and Expenditure Data

Specific recipient and expenditure data on the indigent care component of AHCCCS are not available.

# ARKANSAS

## I. STATE INDIGENT CARE PROGRAMS

### A. Indigent Health Care Program

During the 1985 legislative session, HB 468 was adopted as Act 411 of the laws of 1985. This act creates two funds and the Indigent Health Care Advisory Council. The Federal Medicaid Rebate (as determined by the Omnibus Budget Reconciliation Act of 1981) to Arkansas for fiscal year 1984, along with any appropriation from the state, shall be deposited into the Indigent Health Care Investment Trust Fund.

These funds are to be invested in such a manner that interest payments resulting from the investments (and the principal if necessary) may be transferred to the Indigent Health Care Fund. The Indigent Health Care Advisory Council determines when funds from the Investment Fund shall be transferred to the Health Care Fund which is used to finance medical care for the poor.

Although the Advisory Council and the Department of Human Services are charged with the responsibility of developing the Indigent Health Care Program, the law gives priority in the expenditure of monies to those policies that have the benefit of matching federal funds (such as Medicaid). The state agency and the Council shall establish policies and regulations that:

- defines medical indigency
- sets as the highest service priority, the utilization of preventive and primary care services
- requires hospitals to provide and an established level of charity care as a condition of receiving Indigent Health Care Program funding (hospitals paying taxes are to be given certain credit for charity care), and
- coordinates indigent health care services with existing primary care services and public and community health care clinics (with priority given to systems delivering obstetrical and child health services)

## B. University of Arkansas for Medical Sciences

In 1959, Act 259 created a county quota system for indigent care provided by the University of Arkansas at Little Rock. Each year the university's Board of Trustees certifies the total number of inpatient hospital beds available for county indigents, based on the funds available during the following 12-month period. Admissions of indigents are then allocated monthly to counties and cities on the basis of population. Counties exceeding the quota are billed for the excess.

The quota system is required by the state as an obligation in return for the state's funding the university's Medical Center. At the time of enactment, some counties were high users of the Medical Center. The advent of the county quota system was an attempt to equalize utilization to all state indigents and bill those counties with high utilization rates.

Enforcement of the county quota system has proven impossible. Quotas are established for each month (not each year); thus, the administration of the program requires extensive tracking. Many counties ignore notices of excess utilization and frequently refuse to certify patients as required by the act. Although the state appropriates money for indigent care, the exact amount spent for indigent care is not known.

## II. LIMITED STATE INDIGENT CARE PROGRAMS

### A. High-Risk Maternity Patients (Act 490)

The state of Arkansas has an agreement (the 490 program) with the Regional Medical Center at Memphis, Tennessee, to reimburse maternity services provided to certain high-risk Arkansas residents. The woman must be a resident of a 9-county area in eastern Arkansas that has been referred by or through the Arkansas Health Department. Specific income standards are established, and the patient's pregnancy must be designated high risk. Necessary conditions for the designation of high risk are based on a medical history, obstetrical history, current pregnancy conditions, and other problems. To receive services, the patient must present a 490 card (issued by the Arkansas Health Department) to the Regional Medical Center in Memphis.



# CALIFORNIA

## I. STATE INDIGENT CARE PROGRAMS

In 1982, a year of severe budget deficits due to Proposition 13 and the recession, the legislature enacted major changes in the state's Title XIX Medicaid and medically indigent programs. Previously, the state provided care to what were categorized as Medically Indigent Adults (MIAs): individuals 19-64 years old with income not greater than 115% of the state AFDC standard and no linkage to a public assistance program. These individuals were provided the same services as categorically needy recipients received under the Title XIX Medicaid program (Medi-Cal). Reimbursement was based on the Medi-Cal rate and was 100% state funded.

Effective January 1, 1983, responsibility for providing necessary health care to MIAs was transferred back to the counties. Certain MIAs remained eligible for Medi-Cal: refugees and Cuban/Haitian entrants through the 18th month of residency in the United States; women with confirmed pregnancies; and adults residing in skilled nursing homes and intermediate care facilities.

Legally the counties always had responsibility for providing medical care to indigents, but in 1971 the state assumed financial responsibility by including them under the Medi-Cal program. Only state funds were used for this group, the MIAs. In return for the transfer of responsibility in 1983, the state was directed to fund the counties -- via a block grant program -- at a sum approximately 70% of what the state would have spent for the MIAs under the Medi-Cal program.

Each county's allocation is based on the average amount expended on county MIAs during calendar years 1980-82. The county average is divided by the statewide expenditures for the same 3-year period and then multiplied by the state allocation (70% of which it would have spent), resulting in a county's allocation. The state funds for the counties are placed in the special Medically Indigent Services Account within the County Health Services Fund.

No matching county funds are required to receive the state allocation. However, as a condition of receiving state funds, a county is prohibited from spending less in any fiscal year

for low-income persons and other persons not eligible for the Medi-Cal program than the county spent in fiscal year 1981-82. Counties are not obligated to pay for any services (including emergency services) that are not provided by, contracted with, or on referral from the county.

Counties with populations under 300,000 (1980 census) have the option of contracting back to the state for the administration of the county MIA program. Under this option, the county adopts the state's standard set of eligibility criteria and benefit coverage. Thirty out of 43 eligible counties elected this option for 1983. The remaining 28 counties have individual programs that vary greatly from each other.

The California profile is divided into two parts: (A) those counties contracting with the state (known as the County Medical Services Program); and (B) those counties receiving state funds but administering their own medically indigent programs (known as the Medically Indigent Services Program).

#### A. County Medical Services Program

Counties with populations under 300,000 (1980 census) have the option of contracting program administrative responsibility back to the state. This component of the California indigent care program is called the County Medical Services Program (CMSP). Under CMSP, the county must adopt the standard set of eligibility criteria and benefit coverage. In return, the state provides a prescribed scope of services, claims processing, and overall program management. All CMSP county allocations from the Medically Indigent Services Account are pooled into a central account, with the state at risk for any costs in excess of the CMSP pooled central account. For the most part, Medi-Cal policies are used under CMSP, with notable exceptions being the use of fee-for-service reimbursement in place of selective contracting and the scope of services, which is less than Medi-Cal. For those services covered by CMSP, Medi-Cal treatment authorization policies are utilized.

##### 1) Eligibility Standards

###### a) Categorical

None

b) Income

Individual ..... \$484/month  
Family of 4 ..... \$884/month

c) Assets

Individual ..... \$1,500  
Family of 4 ..... \$2,400

The home and the automobile are excluded.

## 2) Services and Providers

a) Services Covered

The services covered under CMSP are not as comprehensive as the categorically needy component of the Title XIX Medicaid program. All inpatient hospital claims must be prior authorized by the local medical field officers.

Services covered under CMSP include the following:

- Inpatient acute hospital
- Outpatient hospital and clinics
- Physicians' services
- Labs and x-rays
- Drugs
- Medical supplies
- Home health
- Chronic hemodialysis
- Medically necessary interfacility transportation
- Oral surgery on an emergency basis
- Outpatient heroin detoxification
- Durable medical equipment
- Prosthetic devices
- Orthotic appliances
- Ambulance for emergency and
- Blood products.

Services specifically not covered under CMSP include:

- Long-term care facilities (SNF/ICF)
- Adults' day health care
- Dental, podiatry, chiropractic, optometry, physical or occupational therapy, speed pathology, psychology, or audiology
- Hearing aids, or eyeglasses



- Nonemergency transportation
- Pregnancy-related services (such individuals are part of the MIA population still eligible for Medi-Cal).

b) Providers and Settings

Providers must be Medi-Cal providers to receive reimbursement under CMSP.

3) Administration

a) Responsible Entities

The state, in conjunction with the counties, establishes the eligibility standards and processes providers' claims. The county conducts the eligibility determination.

b) Funding Source

The CMSP program is 100% state funded.

c) Reimbursement Methodology

The Medi-Cal fee-for-service schedule is the basis for CMSP payment.

4) Recipient and Expenditure Data

a) Total Expenditures

For fiscal year 1983-84, the state spent an estimated \$35.5 million. Approximately 8% of the state's Medically Indigent Services Account is distributed to CMSP counties.

b) Recipients Served

The original estimate of CMSP was 5,000 recipients per month.

## B. Medically Indigent Services Program

Under AB 799 and SB 2012 of 1982, counties are responsible for directly providing, contracting for, or referring patients to health care services covered under their programs. Counties with populations greater than 300,00 (and those counties not electing to contract with the state under CMSP) administer their own medically indigent programs. Counties with self-administered programs are called Medically Indigent Services Program (MISP) counties. Eligibility standards, scope of benefits, and payment rates are determined by each MISP county. The only state involvement is the state funding allocation from the Medically Indigent Services Account of the County Health Services Fund.

With so few state-administered restrictions, it is not surprising to see the great variety in MISP county medically indigent programs. Counties are at liberty to use their county public hospitals or contract with other providers, including HMOs, primary care clinics, and hospitals. Most MISP counties use their county public hospitals (if one exists) and clinics as a foundation for their medically indigent program and contract with other providers for specialty services or to increase access to medical care.

The MISP profile summarizes the key policies of the MISP counties. For more detailed information on each MISP county program, the reader is urged to contact the County Medical Services Section of the California Department of Health Services, Office of County Health Services, 714 P Street, Sacramento, California 95814 for a useful document titled, County Medically Indigent Services Program, Independent County Summary Fact Book, 1983-84. The same office shall be issuing 4 regional fact books that will describe in even greater detail, each county's MISP program.

### 1) Eligibility Standards

Varies by county.

### 2) Services and Providers

#### a) Services Covered

Of the 28 MISP counties for fiscal year 1983-84:

- All counties cover emergency and nonemergency inpatient hospital care.
- All counties cover emergency and nonemergency

- physicians' office visits.
- All counties cover outpatient pharmacy.
  - Twenty-five counties cover physical therapy.
  - Twenty-four counties cover dental services and emergency transportation.
  - Twenty-three counties cover outpatient mental health visits.
  - Twenty-two counties cover inpatient mental health visits, family planning and occupational therapy.
  - Twenty-one counties cover inpatient rehabilitation, nurse anesthetist services, and kidney dialysis;
  - Twenty counties cover orthotic and prosthetic devices and durable medical equipment;
  - Seventeen counties cover optometric services and nonemergency transportation.
  - Sixteen counties cover speech pathology, audiology, and outpatient rehabilitation.
  - About half the counties cover paramedic services, psychology, podiatry, and home health services.

Limits on the scope, duration, or frequency of services provided to recipients vary by county. Twelve counties provide medical care that a physician deems necessary. Six counties offer the same services with the same limits as the Medi-Cal program, while two other counties have modified Medi-Cal coverage. Four counties cover the services offered under the County Medical Services Program (Kern County includes those services deemed necessary by a physician). The remaining four counties have benefit coverage that is an expanded version of CMSP services.

In general, any services provided outside a county's facility requires prior authorization. Some counties, however, such as Santa Barbara and Sacramento, require prior authorization of all inpatient and specialty care.

#### b) Providers and Settings

Counties are permitted to restrict the providers that may receive payment to those having a contract with the county. Some counties limit the provision of care to their public hospitals and its clinics. Eleven of the MISF counties have such a county-based system.

If a county does not have a public hospital or it is inadequate to meet the demand for medical care by the county's medically indigent, a county will



contract with other providers. Some 12 counties that use public facilities have elected to contract with private providers: Santa Cruz County supplements its clinics by contracting with three private hospitals, while Alameda County supplements its two county hospitals with 18 non-county-owned facilities and community clinics.

The remaining five MISP counties rely solely on contracts with private facilities and clinics for the delivery of services. Contra Costa County enrolls its entire medically indigent adult population in an HMO.

### 3) Administration

#### a) Responsible Entities

MISP counties establish the eligibility standards, determine eligibility, and process providers' claims. The specific unit responsible for each function varies by county, however. Eligibility is determined by the county social service organization, the county health facility, or the staff of the contracting hospital or clinic. The processing and reimbursement of claims also varies by county. It can be done by the county hospital, the county auditor general, a private contractor, or the county health department.

#### b) Funding Source

A percentage breakdown of state/county funding under MISP is not available. The 1983-84 state appropriation for MISP counties was \$440.4 million. Data on the amount counties spent in addition to the MISP block grant are unavailable.

#### c) Reimbursement Methodology

Varies by county.

### 4) Recipient and Expenditure Data

#### a) Total Expenditures

In fiscal year 1983-84, the state allocated \$440 million to the MISP counties. Approximately 92% of the state's Medically Indigent Services Account is distributed to CMSP counties.

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b) Recipients Served

Not available.

V. CERTIFICATE OF NEED PROVISIONS AFFECTING INDIGENT CARE

California enacted a law (S.B. 2062, Chapter 1745, Laws 1984) in 1984 that directs the Office of Statewide Health Planning and Development to exempt health care projects of a health facility from the requirement for a certificate of need if it agrees to provide free health care services to indigents over a period of at least 5 years. The dollar value of the free care must equal the dollar value of the completed project, and the annual dollar value of free care must equal at least 10% of the project value. If the health care facility does not meet the terms of the agreement, the State Department of Health Services is required to suspend the facility's license until it complies.

California's CON program is being phased out, with a final expiration date of January 1, 1987.

# COLORADO

## I. STATE INDIGENT CARE PROGRAMS

### A. Statewide Medically Indigent Program

The Statewide Medically Indigent Program consists of three major components: the University of Colorado Hospital (Colorado General) and the University of Colorado medical faculty, which receive funds through university appropriations; Denver General Hospital and other participating hospitals, which receive funds under another appropriation unit; and the Community Maternity Program. (The Community Maternity Program, established to serve an indigent population with special needs, is described in section B.)

Although the Statewide Medically Indigent Program consists of two budget units and numerous providers, the program's uniformity is a result of having sole administrative responsibility under one entity, the University of Colorado Health Sciences Center. The Health Sciences Center establishes the eligibility criteria and reimburses providers.

#### 1) Eligibility Standards

The Health Sciences Center has uniform eligibility criteria based on ability to pay. As an individual's income increases, the person's financial liability (that is, the portion of the medical bill the person is responsible for) increases.

For example, in fiscal year 1983, an individual with an annual income below \$4,860 would be responsible for \$140 of the total inpatient hospital bill, \$70 for inpatient physician expenses, and 25% of outpatient physician or outpatient hospital bills. An individual with income between \$8,221 and \$9,400 would be responsible for \$980 of the inpatient hospital bill, \$430 for physician services, and all the costs incurred for outpatient physician or outpatient hospital charges. It is the responsibility of the provider to collect the copayment from the recipient.



A ceiling of 230% of the poverty level for any given size of family is imposed, above which the individual is totally responsible for all hospital and physician bills.

Under the eligibility criteria, the principal home and automobile are not exempt.

## 2) Services and Providers

### a) Services Covered

The following services are provided under the program:

- Inpatient hospital
- Outpatient hospital
- Hospital-based physicians
- Lab and x-ray
- Physician services
- Prescription drugs.

Because the reimbursement levels tend to be less than cost (approximately 50%), providers may be unable to provide the complete range of services to all indigents qualifying during the entire fiscal year. Nonetheless, providers must provide emergency or urgent care throughout the contract year. All other care can be provided up to the physical, staff, and financial capabilities of the provider.

### b) Providers and Settings

Providers eligible for reimbursement under the Health Sciences Center-administered Statewide Medically Indigent Program include hospitals, associated physicians, health maintenance organizations, and clinics. Each provider has an obligation to provide a minimum of 3% charity care of adjusted operating expenses based on the previous year's operating expenses. This charity care requirement is in addition to any Hill-Burton requirement.

Under the contract provisions, all monies received by the provider must be used in the following manner: 40% for inpatient medical care; 59% for outpatient care (5% of which must be for preventative care); and 1% for transportation. The Health Sciences Center may authorize a specified deviation from the above percentages if it is adequately justified. In fiscal year 1982, most

participating providers requested and received approvals for such deviations to cover more inpatient care.

A provider may be designated a specialty health care provider for unique or specialized services not commonly available through general acute care hospitals or health centers.

In fiscal year 1984, 27 providers participated; in fiscal year 1985, 31 are expected to participate.

### 3) Administration

#### a) Responsible Entities

The University of Colorado Health Sciences Center (UCHSC) is responsible for the administration of the Statewide Medically Indigent Program. The Health Sciences Center establishes the ability-to-pay scale used as the eligibility standard and reimburses participating providers. The individual provider -- the hospital, HMO, clinic, or association of physicians -- certifies an applicant's eligibility and is responsible for collecting the patient's share of medical costs.

#### b) Funding Source

The Statewide Medically Indigent Program is 100% funded by the state.

#### c) Reimbursement Methodology

Providers are paid on a prorated share of the medically indigent appropriation on a monthly basis. At the end of the year a final accounting assures that all providers receive the same percentage of costs. The share is based on the percentage of medical claims submitted. Thus, the percentage of costs reimbursed depends on the number of contracting providers and medically indigent patients served; in fiscal year 1982, the reimbursement as a percentage of costs was 30%.

## 4) Recipient and Expenditure Data

a) Total Expenditures

## Statewide Medically Indigent Funding\*

	FY 82	FY 83
U. of Colorado Hosp.	\$16.9	\$14.1
Health Sciences Center**	1.0	1.4
Denver General Hosp.	15.7	16.3
Out-state providers	0.8	1.5
Administration		less than 0.1
Total	\$34.4	\$33.3

Figures are in millions, appropriations before budget reductions.

\* Although most cost figures cited for the Statewide Medically Indigent Program include expenditures for the Community Maternity Program, in this survey, the latter program's expenditures have been presented in section B. The figure for University Hospital is not a line item but technically an operating subsidy to University Hospital.

\*\* Payment to university medical faculty who treat indigents.

b) Recipients Served

The following figures are unduplicated data from fiscal year 1982: 1,325 were served by the out-state providers (non-Denver-Boulder Metropolitan area), 36,471 were served by Denver General (which is based on calendar year figures), and 35,986 were served by the University of Colorado Health Sciences Center (Colorado General and the University of Colorado medical staff providing indigent care).

## 5) Recent and Proposed Changes

- In 1982, administration of the Statewide Medically Indigent Program was transferred from the Department of Social Services to the University of Colorado Health Sciences Center in an effort to consolidate various related indigent programs.



- Since 1982, eligibility reimbursement and administrative guidelines have been made uniform and substantially streamlined.
- Since 1982, uniform data related to clinical service and some demographic and reimbursement activity have been reported routinely by all participating providers.
- From 1982 to the present, the number of participating medically indigent providers has grown from three to 31.
- In 1982, emergency/urgent care was prioritized for provision of services and coverage by the program.
- In 1983, the indigent programs were established for the first time by statute.
- In 1984, providers were designated for the first time as general or specialty providers.
- In 1985, SB 21 was enacted. SB 21 directs the state to award contracts with providers in such a manner that it enhances participation from providers outside of the Denver-Boulder area.

## B. Community Maternity Program

Historically, most of Colorado's indigent care funds have been directed toward two major hospitals: Denver General and the University of Colorado Hospital-Colorado General. This practice resulted in limited access to residents living outside the Denver-Boulder areas. The limited access was acutely felt by medically indigent pregnant women living in the out-state area.

The Community Maternity Program (CMP) was established to reimburse hospitals (other than Denver General and Colorado General) for the provision of delivery services to women with low-risk pregnancies. The following section describes the CMP, but references to Colorado's Statewide Medically Indigent Program frequently include the CMP as a component and technically it is, as the funding and administrative entity are the same.

### 1) Eligibility Standards

The University of Colorado Health Sciences Center develops eligibility criteria based on the patient's ability to pay (see "Eligibility Standards" for Colorado's Statewide Medically Indigent Program). Each woman is expected to pay at least \$100, however. For

fiscal year 1985 the minimum amount has increased to \$200.

## 2) Services and Providers

### a) Services Covered

Services covered include hospital and inpatient obstetrical services and limited home health services to encourage early discharge.

### b) Providers and Settings

Hospitals and home health agencies are eligible to receive reimbursement if they sign contracts.

## 3) Administration

### a) Responsible Entities

The University of Colorado Health Sciences Center establishes the ability-to-pay eligibility criteria, and the Department of Health reimburses the providers. The contracting providers certify an applicant's eligibility.

### b) Funding Source

The CMP is 100% state funded.

### c) Reimbursement Methodology

For fiscal year 1983, the total amount to be paid by the state to each hospital--including home health care--is the lesser of \$1,056 per case or the cost of care for the lowest-cost hospital in the hospital's service area. The rate is determined prospectively, with each hospital's payment rate set at the beginning of the fiscal year. For fiscal year 1985 the total amount to be paid by the state was increased to \$1,149.

## 4) Recipient and Expenditure Data

a) Total Expenditures

## Community Maternity Program Funding

	FY 79	FY 80	FY 81	FY 82	FY 83*
CMP	\$0.13	\$0.95	\$1.5	\$1.2	\$1.8

(in millions)

\*Appropriated

b) Recipients Served

## Community Maternity Program Recipients\*

	FY 79	FY 80	FY 81	FY 82
CMP	151	781	1,175	1,206

\* Unduplicated, annual count





# CONNECTICUT

## I. STATE INDIGENT CARE PROGRAMS

### A. General Assistance Medical Aid

The General Assistance Medical Aid program is a mandatory program jointly administered by the 169 towns of Connecticut and supervised and monitored by the state Department of Income Maintenance. The towns are required to provide medically necessary services to persons who are eligible for General Assistance Financial Aid and to persons who are not eligible for General Assistance Financial Aid but are unable to pay for medical treatment over a 2-year period. There is no county government in Connecticut; each town makes its own appropriation to fund its program. The state Department of Income Maintenance reimburses towns quarterly for proper expenditures. The state share is 90%, except that medical expenditures on behalf of workfare participants are totally paid by the state. Reimbursements are for programmatic expenditures only. The state does not finance the towns' administrative expenses.

#### 1) Eligibility Standards

##### a) Categorical

Recipients of General Assistance Financial Aid are automatically eligible, and medically needy persons not eligible for Title XIX Medicaid may be eligible if they are unable to pay bills for medically necessary services over a 2-year period, provided that such person has no assets that can be used to pay such bills.

##### b) Income

Income limits correspond to those of Title XIX Medicaid. A single individual living in Hartford may qualify if his or her annual income is less than \$4,000 after deduction of employment expenses. A

person whose income is greater than the standard may nonetheless qualify, provided that the amount of the excess income over the standard is used to defray the medical expenses.

c) Assets

Recipients must be without available assets. Ownership of an automobile valued at less than \$1,500 does not affect eligibility.

d) Other

Eligible recipients must reside in the town in which assistance has been requested. A person who does not have an established place of abode in that town but who nonetheless overtly expresses an intent to reside there, or a person having no established place of abode but who becomes in need of medical aid while in the town, may be deemed to be a resident. Disputes between towns regarding residency may be referred to the Department of Income Maintenance for resolution.

2) Services and Providers

a) Services Covered

The state requires the towns to provide medically necessary services, including:

- Physician services performed by the physician himself or under his direction.
- Hospital services, including inpatient or outpatient care.
- Community clinic services, to include but not limited to psychiatric outpatient clinics associated with an institution, and drug or alcohol rehabilitation clinics.
- Prescription drugs, but not over-the-counter drugs, and durable medical goods or prosthetic devices prescribed by a physician, if failure to provide same would render the recipient unemployable.
- Eyeglasses, including contact lenses in cases where an optometrist, ophthalmologist or physician certifies that eyeglasses alone will not improve the person's visual acuity.
- Hearing aids, including batteries for their use.
- Laboratory and x-ray services performed in a hospital or in an independent laboratory.
- Emergency dental services, including the



- . purchase, repair, or replacement of dentures, bridges, and plates, when a dentist certifies that any such item is necessary to the recipient's good health or improves the recipient's employability.
- Emergency medical transportation provided by a licensed ambulance company.
- Convalescent home services for persons who were receiving such services paid for by a town or city before to January 1, 1983.
- Medical examinations needed to determine an individual's employability for participation in the town's Mandatory Work, Education, and Training program, or when requested by an attorney to establish an applicant's or recipient's eligibility for federal Supplemental Security Income benefits.

"Medically necessary" means that the services provided, or to be provided, are required for the maintenance, improvement, or protection of health, or lessening of illness, disability, or pain, including preventive, diagnostic, therapeutic, or palliative treatment of condition, injury, illness, or disease; but not including services that are elective, cosmetic, or experimental.

b) Providers and Settings

Any health or mental health residential facility, such as a hospital or nursing home, a physician or licensed practitioner of the healing arts, a dentist, a registered or licensed practical nurse, a physical or occupational therapist, an optometrist or optician, a psychologist, a drug or alcoholism counselor, a pharmacy, or a licensed ambulance company is considered an eligible medical provider. Nonpermanent housing facilities, such as a half-way house or a shelter for battered women, do not qualify as medical providers.

Towns may prohibit medical providers from participating in their General Assistance Medical Aid Program if the town has evidence that such provider has repeatedly prescribed or provided treatment or services that are not medically necessary.

### 3) Administration

#### a) Responsible Entities

The General Assistance Medical Aid program is directly administered by each of the state's 169 towns. The town conducts the eligibility determination and process providers' claims. The state Department of Income Maintenance establishes the eligibility standards and the service coverage, and monitors local performance to ensure compliance.

#### b) Funding Source

The towns submit quarterly reimbursement requests to the state Department of Income Maintenance. Qualifying expenditures are reimbursed at 90%, except that expenditures on behalf of participants in the Mandatory Work, Education, and Training program are reimbursed at 100%. Further, towns are reimbursed at 100% for expenditures on behalf of medically needy nonresidents, provided that such individuals have no permanent residence elsewhere.

Overall, in fiscal year 1983, the state paid 92% of the program's expenditures.

#### c) Reimbursement Methodology

Medical providers may not be reimbursed at a rate in excess of the rates established by the Department of Income Maintenance for the Title XIX Medicaid program.

Medical treatment given by a provider must be limited to the least costly procedure readily available for the specific ailment, unless the local welfare official, after first obtaining written documentation that a more costly procedure is required, gives prior written authorization for the procedure.

## 4) Recipient and Expenditure Data

a) Total Expenditures

## General Assistance Medical Aid\*

Service	FY 80	FY 81	FY 82	FY 83	FY 84
Hospital	\$ 5.31	\$ 5.50	\$ 5.61	\$ 6.72	\$10.56
Professional					
fee	2.30	2.74	3.97	7.92	9.41
Convalescent	0.06	0.02	0.07	0.07	0.06
Total	\$ 7.67	\$ 8.26	\$ 9.65	\$14.71	\$20.03

(in millions)

\* State and town expenditures

b) Recipients Served

Not available.

## 5) Recent and Proposed Changes

In July 1981, Connecticut dropped a 100% state-funded, state-administered financial/medical program for incapacitated persons not eligible for Title XIX Medicaid.

Public Act 84-168, enacted by the 1984 General Assembly, requires that when a resident of any town enters an institution and is subsequently discharged, such a person if medically needy will be eligible for General Assistance Medical Aid, to be provided by the town of origin regardless of where such a person actually settles after such a discharge for 60 days after discharge.

## II. LIMITED STATE INDIGENT CARE PROGRAMS

A. Soldiers, Sailors, and Marines Fund

The Soldiers, Sailors, and Marines Fund is a state-funded program that provides short-term cash assistance and health care services to needy veterans. Interest from a \$32 million



designated fund provides program operating expenses. The program provides cash assistance to indigent veterans who are Connecticut veterans for 16 weeks, except in cases of illness or disability, when benefits are given for 26 to 28 weeks. In addition to cash assistance, the program provides funding for clothing, shelter, health care, and burial expenses. The program's budget for FY 1984 was \$3,100,000; approximately 7,500 veterans received services. Program officials estimate that approximately \$1 million of the program's budget was spent on providing health care to approximately 100 to 200 veterans.

### III. INDIGENT CARE PROVISIONS UNDER RATE SETTING

S.B. 61 (Public Act 84-315), which was passed by the Connecticut legislature during its 1984 session, authorized the development of an all-payer, prospective reimbursement system to take effect in October 1985. The legislation directs that the new payment system, which will replace rate review for charge-based payers, include a Medicare discount to ensure that Medicare payments under this system do not exceed those that would have been made under Medicare's DRG-based prospective pricing system. Medicaid will also receive a discount under the new system so that federal Medicaid payments will not exceed those that would have been made to the state under the provisions of the Tax Equity and Fiscal Responsibility Act of 1982.

Section II of the law directs the Commission on Hospitals and Health Care to determine a reasonable level of uncompensated care for both inpatient and outpatient services and further directs it to consider the number of Medicaid recipients served by each hospital, its level of bad debt, and socio-economic characteristics of the hospital's service area, such as the unemployment rate, the number of people receiving public assistance, and any other factors it considers relevant. The commission is required to set charges for each hospital sufficient to fund the level of uncompensated care it has determined is reasonable.

The law also charges the commission with assuring annually that an adequate level of care is being provided to the indigent and uninsured. Each hospital is required to file its policy statements regarding free or reduced-cost services for indigent people each year to assist the commission in making these assurances.

#### IV. HEALTH INSURANCE ALTERNATIVES

##### A. Comprehensive Health Insurance and Risk Pools

In 1975, Connecticut passed a law (Public Act 75-616) that requires all insurance carriers in the state to offer comprehensive health care plans on both a group and individual basis. The plan must meet specified minimum standards and may be provided to individuals through their employers. The law also established reinsurance associations (risk pools) for individuals who could not otherwise obtain coverage. Insurance carriers are required to make individual comprehensive health care plans available to all state residents, except those eligible for Medicare, and are required to make group comprehensive insurance plans available to Connecticut employers who employ at least three people.

The law requires all private insurers and self-insurers to belong to the state risk-sharing pool, called the Health Reinsurance Association (HRA). Under the law, hospital and medical service corporations were permitted to set up their own separate risk pools, and, until September 1, 1984, Blue Cross of Connecticut had operated its own risk pool, which was much larger than the one operated by the state. During 1984, however, Blue Cross converted from a hospital service corporation to a mutual company and thus became ineligible to maintain its own risk pool. Its risk pool has now been merged with the state's Health Reinsurance Association.

##### 1) Covered Services

Both individual and group comprehensive health care plans must adhere to minimum benefit standards or supply "equivalent" benefits-catastrophic coverage held in conjunction with other basic medical-surgical and hospital insurance plans. Plans must include:

- hospital services;
- most physician services, or physician-directed nursing services (except mental and dental);
- diagnosis and treatment of mental conditions by a physician or physician-directed personnel up to a yearly maximum of \$1,000 (outpatient only);
- legend drugs prescribed by a physician, if SNF care follows a hospital stay of at least 3 consecutive days and commences within 14 days of hospital discharge for the same condition;
- home health services up to 180 visits in a calendar year; the services must follow an inpatient stay in a hospital or SNF of at least 3 consecutive days for the same condition



- and begin within 7 days of discharge;
- radium or other radioactive materials;
- oxygen;
- anesthetics;
- rental of some durable medical equipment;
- diagnostic x-rays and lab tests;
- nondental prostheses;
- some oral surgery;
- licensed physical therapy directed by a physician;
- ambulance transportation to the nearest appropriate treatment facility;
- other medically necessary services approved by the insurance commissioner;
- alcoholism treatment in a facility licensed by the state for at least 45 days in a calendar year; and
- pregnancy (\$250 toward childbirth) and some complications of pregnancy (no limitations).

Comprehensive insurance plans must also meet certain requirements for deductibles and copayments. Both individual and group plans must be sold with one of three different deductibles: a low option with a \$200 deductible; a middle option with \$500 deductible; or a high option with a \$750 deductible. Deductibles apply to each person covered under a comprehensive plan and are applied to both inpatient and outpatient services. In addition, state law requires a 20% maximum copayment for charges above the deductible up to a yearly maximum of \$1,000 per covered individual and \$2,000 per covered family. One hundred percent of reasonable charges are covered up to a policy maximum, although reimbursement is limited to a \$1,000 maximum for outpatient mental health care per calendar year. Lifetime benefits of at least \$1 million per individual are available to each policyholder. Plans have a 6-month preexisting condition clause but can not exclude coverage for a condition for more than 12 months following the effective date of the policy.

The 1975 law created the Health Reinsurance Association to make comprehensive health insurance plans available to persons who cannot purchase comparable coverage from any other source. The HRA is supervised by a 7-member board selected by the participating members (all insurers and self-insurers in the state) and the Insurance Department.

The HRA is permitted to charge higher rates because it insures higher-risk persons, but HRA's rates cannot be "excessive, inadequate, or unfairly discriminatory." Rates can range from no less than 125% to no more than 150% of the average group rate charged under a comparable policy covering 10 persons. Premiums vary for individuals and group policies issued through the HRA; group rates may be adjusted for variations among areas in provider's rates, but individual rates cannot be adjusted. If expenditures exceed revenues from premiums, HRA members assume the loss in proportion to their respective shares of the total health insurance premiums issued in the state during that year.



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## 2) Experience

The 1975 act allowed the formation of risk pools for both group and individual policies. Virtually no group comprehensive health care plans have been sold, however, and large volumes of individual policies have not been sold either. At least part of the reason stems from the fact that both Blue Cross and commercial insurers have marketed their policies in preference to the state risk pools.

Until September 1984, when Blue Cross became a mutual company instead of a hospital service corporation, two risk pools operated in the state. Blue Cross's pool was always much larger, experienced lower administrative costs and better loss ratios than the HRA's plan, and offered lower premiums.



# **DELAWARE**

## **I. STATE INDIGENT CARE PROGRAMS**

Delaware does not have a state or state-county indigent care program. Some county general assistance programs may reimburse providers for medical care, but the benefits and eligibility criteria vary by county.





# DISTRICT OF COLUMBIA

## I. STATE INDIGENT CARE PROGRAMS

### A. Medical Charities Program

The Medical Charities Program (MCP) provides inpatient and outpatient hospital services for general public assistance recipients. This program is to reimburse indigent care provided by District of Columbia hospitals (other than D.C. General, which receives an annual appropriation from the D.C. government).

The hospitals must conduct the eligibility determination based on the same financial eligibility as the Title XIX Medicaid program. Hospitals are reimbursed at the following rates:

Inpatient Hospital-Adult .....	\$76/day
Inpatient Newborn .....	\$20/day
Emergency Room and Outpatient Hospital .....	\$12/day

#### Expenditures

	FY 80	FY 81	FY 82	FY 83*
MCP	\$2.48	\$2.57	\$2.51	\$1.7

(in millions)

\* Appropriated

## V. CERTIFICATE OF NEED PROVISIONS AFFECTING INDIGENT CARE

The District of Columbia's Certificate of Need Program requires the designated health planning and development agency to monitor

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facilities' efforts to improve access. A facility's certificate of need application will not be approved until the agency issues written findings that the facility is in compliance with the District of Columbia's access provisions and the Hill-Burton provisions.

Each hospital's obligation to provide free care must be posted within the facility and annual compliance reports must be submitted to the state agency. Facilities not meeting its free care obligations -- based on the hospital's service area and a general provision defining free care as 3 percent of the facility's total operating expenses minus Medicaid and Medicare reimbursement -- must develop a compliance plan. No certificate of need application may be approved for such facilities until the facility's free care obligations are met.



# FLORIDA

## I. STATE INDIGENT CARE PROGRAMS

### A. Health Care Responsibility Act

The Florida Health Care Responsibility Act establishes the county as the responsible entity for providing necessary medical care to resident indigents. No provisions mandate minimum eligibility criteria or benefit coverage, and the state does not provide any funds.

The act also establishes the county where the indigent resides as the entity financially responsible when the indigent travels to another county to receive medical care. The responsibility for reimbursing inpatient hospital care is limited to 12 days per year, with payment set at the Title XIX Medicaid rate.

## II. LIMITED STATE INDIGENT CARE PROGRAMS

### A. Primary Care Networks

The 1984 Health Care Access Act included a provision authorizing the use of up to \$10 million from the Public Assistance Medical Trust Fund to establish primary care programs for low-income persons through county public health units. The Department of Health and Rehabilitative Services, Health Programs Office, issued requests for proposals to solicit contractors for the program. The department expects some programs to become operational during 1985.

The funded programs will provide comprehensive health services, including 24-hour coverage, for indigent persons. The program's intent is to provide services to indigent persons not currently receiving care, rather than assuming funding for care already being provided. Care will be free to those under 100% of the

federal poverty levels, while those with incomes ranging between 100% to 200% of the poverty level will receive discounts ranging from 90% to 10%.

B. Regional Perinatal Intensive Care Program

Florida has a perinatal intensive care program that is state funded and administered. State expenditures for the program were \$24.5 million in FY 1983, with projected expenditures of \$25.9 million in FY 1984. Those eligible for participation include persons whose annual income (for a family of 4) is \$9,000 or less. Medicaid-eligible persons are also covered after Medicaid funds for covered services are exhausted. A spend-down of \$250 for medical expenditures is also permitted for persons whose income exceeds eligibility standards. Services covered include prenatal care for women, inpatient hospital services for babies, and postservice annual screening services for children. Services are provided by designated hospitals and physicians under contract to the children's medical services program.

#### IV. HEALTH INSURANCE ALTERNATIVES

A. Comprehensive Health Insurance and Risk Pools

In 1982, Florida enacted a comprehensive health insurance statute designed to make health insurance available to people who are unable to obtain it because of their poor health status. All insurers in the state, except self-insurers, are required to participate in the association and share in losses, although they are not required to offer comprehensive health insurance policies. Insurers are required to publicize the plan's availability; coverage is available to persons who have been refused coverage by two carriers.

Minimum Standards

Initial rates for association policies are set at 150% of the average standard risk rates and are not to exceed 200% of the standard risk rates. These limitations on rates will be repealed on October 1, 1987. Losses incurred by the association and the plan's administrative expenses are distributed among insurers in proportion to the volume of their claims to the total number of policies sold in the state.

## 1) Covered Services

Covered services include:

- hospital services;
- professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than medical or dental, that are rendered by a physician or under a physician's direction;
- drugs requiring a physician's prescription;
- services of a skilled nursing facility for Medicare-eligible persons, not to exceed 120 days a year, if the services are Medicare reimbursable;
- home health services that are Medicare reimbursable;
- radium or other radioactive materials;
- oxygen;
- anesthetics;
- prostheses, other than dental prostheses;
- rental or purchase of durable medical equipment other than eyeglasses or hearing aids;
- diagnostic x-rays and laboratory tests;
- specified types of oral surgery;
- services of a physical therapist;
- transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;
- services of a licensed skilled nursing facility for not more than 100 days a year;
- processing of blood;
- services for the diagnosis and treatment of mental and nervous disorders, with the insurance plan required to make a 50% copayment.

Copayments for outpatient psychiatric treatments are limited to \$4,000.

Reimbursement is based on UCR (usual, customary or reasonable) principles. Insurers can offer plans with deductibles of \$1,000, \$1,500, or \$2,000; if two members of the same family satisfy their plan's deductible, other family members are exempt from paying the deductible for that calendar year.

## 2) Experience

The plan began operation on July 1, 1982, and policies became available for sale in September 1983. To date, 257 policies have been sold; the plan has not yet experienced any losses, although that is likely to change when the 12-month preexisting condition limitation has expired. According to program officials, no formal enrollment targets were established for the program, so it is difficult to determine what percentage of its target population the program is reaching. In any event, the program must have several years of operation before it can be thoroughly evaluated.





# GEORGIA

## I. STATE INDIGENT CARE PROGRAMS

Georgia does not have a state or state-county indigent care program. Some county general assistance programs may reimburse providers for medical care, but the benefits and eligibility criteria vary by county.

### Recent Changes

Georgia enacted HB 483 in 1985. The act requires each hospital to submit a semiannual report that includes the following information:

- total gross revenues;
- bad debts;
- amount of free care extended, excluding bad debts;
- contractual adjustments;
- amount of care provided under a Hill-Burton requirement;
- amount of charity care provided to indigent persons; and the
- amount of outside sources of funding (governmental, philanthropic, etc.) including the proportion of any such funding dedicated to the care of indigent persons.

For cases involving indigent persons, hospitals are required to report:

- number of persons treated;
- number of inpatients and outpatients;
- total patient days;
- number of patients categorized by county of residence; and
- indigent care costs incurred by the hospital by county of residence.

The law defines an indigent person as having a maximum allowable income level of 125 percent of the federal poverty guideline. In the event the state health planning agency does not receive a semi-annual report or receives an incomplete report, no certificate of need application shall be considered complete for that hospital.

In the same session, the legislature adopted HB 484 to clarify

existing law prohibiting hospitals from denying hospital care to pregnant women. The law, which is limited to county funds, was amended to:

- clarify reimbursement methodology, which is to be based on the Medicaid rate,
- define indigency as the inability to pay the entire cost of care and sets an income standard of 125 percent of the federal poverty level in effect May 1, 1985;
- require the hospital to certify the patient claiming indigency is not eligible for any third party coverage, public or private;
- state that by acceptance of services, the indigent assigns the right of third party recovery to the county;
- require the indigent patient to cooperate in identifying, if necessary, the father for purposes of repayment for the cost of care; and
- limits provider liability for rendering care as required under this statute unless there is gross negligence or a willfull failure to comply.

#### V. CERTIFICATE OF NEED PROVISIONS AFFECTING INDIGENT CARE

Georgia implemented a regulation (Certificate of Need Chapter 272-2-0.03 (4) (f)) in 1984 that requires parties purchasing or leasing a public hospital to provide an amount equal to 3% of the hospital's gross revenue in indigent care in order for the sale or lease to be approved.



# HAWAII

## I. STATE INDIGENT CARE PROGRAMS

### A. State-Only Medicaid

#### 1) Eligibility Standards

##### a) Categorical

General Assistance recipients are automatically eligible for State-Only Medicaid, and others may qualify for medical assistance as medically needy under spend-down provisions.

##### b) Income

Individual .....	\$300/month
Family of 4 .....	\$550/month

##### c) Assets

Individual .....	\$1,500
Family of 4 .....	\$2,750

The home and one automobile up to a \$1,500 equity value are excluded.

#### 2) Services and Providers

##### a) Services Covered

Under State-Only Medicaid, the services covered and the limitations on services are the same as the state's categorically needy component of the Title XIX Medicaid program.

b) Providers and Settings

Providers must be Title XIX Medicaid providers to receive reimbursement.

## 3) Administration

a) Responsible Entities

The state establishes the eligibility standards, conducts the eligibility determination and processes providers' claims.

b) Funding Source

The State-Only Medicaid program is 100% funded by the state.

c) Reimbursement Methodology

The reimbursement methodology is the same as that for the Title XIX Medicaid program, which is on a cost-incurred basis.

## 4) Recipient and Expenditure Data

a) Total Expenditures

## State-Only Medicaid Expenditures\*

	FY 81	FY 82	FY 83
State-Only	\$20.5	\$23.0	\$27.5

(in millions)

\* The figures represent the medical expenditures incurred by General Assistance recipients and the medically needy under the spend-down provision.

b) Recipients Served

## State-Only Medicaid Recipients\*

	FY 81	FY 82	FY 83
State-Only	12,938	12,627	11,326

\* Annual figures, duplicated count.

## 5) Recent and Proposed Changes

The state agency is proposing to adopt a prospective payment methodology for hospitals.

## IV. HEALTH INSURANCE ALTERNATIVES

A. Mandatory Health Insurance

In 1974, Hawaii became the first (and only) state to enact a mandatory health insurance program. The Prepaid Health Care Act of 1974 requires most employers in the state to provide health insurance for their full-time employees and establishes basic minimum benefit standards. It permits coverage to be provided through nonprofit organizations, commercial insurers, health maintenance organizations, or other organizations that provide direct health care services.

The law specifies that employers, not employees, choose the type of insurance plan and the plan administrator, although employees frequently have input through collective bargaining agreements. Employers must offer coverage to full-time employees, which the act defines as persons who have worked for one employer for at least 4 weeks, at least 20 hours a week, and have been paid a monthly wage of at least 86.67 times the minimum hourly wage. The law does not apply to government employees, seasonal agricultural laborers, individuals covered by a federal program, those who receive public assistance or who depend on prayer or other spiritual means for healing, individuals in family employment, salesmen or brokers paid solely on commission, and those covered as dependents under another health plan. Coverage for full-time employees is mandatory except for persons who are covered as dependents on other policies. Coverage for dependents of full-time employees is optional.



### 1) Covered Services

Minimum required services include:

- 120 days of inpatient care in a calendar year, including room, regular and special diets, and general nursing care;
- operating room charges;
- surgical supplies;
- anesthesia services and supplies;
- drugs;
- dressings;
- oxygen;
- antibiotics;
- blood transfusion services;
- hospital outpatient care facilities for surgical procedures or medical care in an emergency;
- surgical and anesthesiology services performed by licensed physicians, and postoperative visits;
- medical benefits, such as necessary home, office, and hospital visits by a physician;
- intensive medical care while hospitalized;
- medical or surgical consultations while hospitalized;
- diagnostic lab services, x-rays, and radiotherapy;
- maternity services, if the employee has been covered by the plan for 9 months before delivery; and
- substance abuse services, including inpatient and outpatient care for diagnosis and treatment of alcoholism and drug addiction.

Detoxification and acute care benefits are provided for hospital care or for treatment in any public or private facility that is properly licensed. Inpatient care for alcohol abuse detoxification is limited to 3 admissions per calendar year, not to exceed 7 days per admission. For other kinds of substance abuse, the inpatient stay is limited to 3 admissions, not to exceed 21 days each.

Employers are required to pay at least one-half of each employee's premium costs; employees' costs are restricted to 1.5% of their gross salaries. In the event that 50% of premium costs exceeds 1.5% of an employee's gross salary, the employer must pay the difference. Some small employers (those who employ fewer than 8 people) are eligible for financial relief from the state if their premium costs exceed 1.5% of their total wage costs and if 5% of their pretax income is directly attributable to the business.

Prepaid health care plans offered by employers must meet the minimum standards imposed by the Prepaid Health Care Act. Both prepaid and indemnity plans must provide benefits that are equal to, or that are a medically reasonable substitute for, those provided by the same type of prepaid health care plan that has the most subscribers in the state. Benefit standards are currently based on the Hawaii Medical Service Plan 4 (Blue Shield) for vendor payment plans and on the Kaiser Health

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Foundation Plan B for direct service plans.

2) Experience

According to the National Center for Health Services report, State Options for Addressing Catastrophic Health Expense, Hawaii's Prepaid Health Care Act has resulted in expanded health insurance coverage in the state, but its impact has been relatively small in view of the already high level of coverage before the bill's passage. A 1978 study by Martin Segal of Hawaii's mandatory health insurance program (the most recent study available) indicates additional coverage for 1974 to 1977, but more than one-half of the increase was attributable to an expansion of private insurance coverage, while another third resulted from increased enrollment in Medicaid. The same study reports that employment-based coverage increased to 78% from 70% during the same period and that the act prompted marginal improvements in the quality of health insurance coverage offered. It estimates that no more than 2% of the state's population remains without insurance.





# IDAHO

## I. STATE INDIGENT CARE PROGRAMS

State law mandates that counties must provide emergency medical assistance to their indigents. The county is authorized to levy an ad valorem tax not to exceed 5 mills on all taxable property for use in funding care for the medically indigent.

The program benefits and eligibility criteria vary by county. Data on recipients are unavailable.

Recently, the Idaho Association of Counties established a catastrophic fund to insure counties against expensive individual claims. At the time of the survey request (June 1984), no county had received payment from the fund.



# ILLINOIS

## I. STATE INDIGENT CARE PROGRAMS

Illinois has two programs addressing the needs of the state's medically indigent: the General Assistance Medical program (GA-M), which is jointly administered by the state and county (or township) governments; and Aid to the Medically Indigent (AMI), which is a state-only program. Both programs offer similar services--called the Basic Health Protection Plan--however General Assistance-Medical (GA-M) had a \$500 limit per inpatient hospital admission from March 1983 through February, 1985.

### A. General Assistance-Medical

Counties and townships are mandated by state law to have a general assistance program. If a county wishes to receive state funding under the GA-Medical program, the county's eligibility criteria must conform to the state's standards. Most counties do not participate under the state program; thus, eligibility criteria and benefits provided vary across county lines.

#### 1) Eligibility Standards

##### a) Categorical

General Assistance recipients are automatically eligible.

##### b) Income

Individual .....	\$144/month
Family of 4 .....	\$368/month

##### c) Assets

Allowable liquid assets are equal to one month's



payment level (i.e., \$144 for one person and \$368 for a family of four). Excluded are: homestead property, household furnishings, clothing, personal effects, and an automobile with an equity value of under \$1,500.

d) Other

If employable, the recipient must participate in a job search program.

2) Services and Providers

a) Services Covered

Under the Basic Health Protection Plan of the GA-Medical program, the following services are covered:

- Inpatient hospital
- Emergency care
- Outpatient surgery
- Physicians
- Lab and x-rays
- Transportation.

Certain additional services are provided to relieve pain, to expedite a discharge, or to alleviate a life-threatening situation: durable medical equipment, drugs, dental care, and prostheses.

b) Providers and Settings

GA-Medical covers the same providers as the Title XIX Medicaid program. Providers must participate in the Title XIX Medicaid program.

3) Administration

a) Responsible Entities

Under the GA-Medical program, the state establishes the eligibility standards for those counties electing to receive state funding. Most counties do not participate. In the counties that do not participate, the GA-Medical program (and the entire county General Assistance program) is totally administered and funded by the counties.

The state administers the General Assistance program in the city of Chicago. In the other participating

counties, the local government administers the GA-Medical program (which includes processing providers' claims and conducting the eligibility determination).

b) Funding Source

For participating counties, the local government must levy a tax of one mill of the latest known equalized evaluation. At the point where the revenues raised by the levy do not meet the cost of services, the state pays for the expenses incurred above the revenue generated by the levy.

4) Recipient and Expenditure Data

General Assistance - Medical Component\*

Services	FY 82	FY 83
Hospital	\$69.6	\$56.0
Physician	13.5	13.1
Drugs	9.3	10.9
Nursing homes	0.5	0.2
Laboratories	**	2.8
Other	**	1.1
Total	\$92.9	\$84.1

(in millions)

\* State and County expenditures.

\*\* This category is included with the other FY 82 figures.

b) Recipients Served

General Assistance - Medical Recipients

	FY 81	FY 82	FY 83
GA-Med	84,922	106,034	130,186

\* Duplicated, annual figures

## B. Aid to the Medically Indigent

The Aid to the Medically Indigent program (AMI) is a uniform, state-administered program for individuals ineligible for Title XIX Medicaid and General Assistance. The program was temporarily suspended the last 5 months of fiscal year 1983 but was reinstated for fiscal year 1984.

### 1) Eligibility Standards

#### a) Categorical

Applicants cannot be eligible for Title XIX Medicaid or General Assistance.

#### b) Income

Individual .....	\$166/month
Family of 4 .....	\$331/month

#### c) Assets

Individual .....	\$400
Family of 4 .....	\$800

### 2) Services and Providers

#### a) Services Covered

Under AMI's Basic Health Protection Plan, the following services are covered:

- Inpatient hospital
- Emergency care
- Outpatient surgery
- Physician services
- Lab and x-rays
- Emergency transportation.

Certain additional services are provided to relieve pain, to expedite a discharge, or to alleviate a life-threatening situation: durable medical equipment, drugs, dental care, and prostheses.



## 3) Administration

a) Responsible Entities

The AMI is administered by the state which, establishes eligibility standards, conducts the eligibility determination, and processes providers' claims.

b) Funding Source

The AMI Program is 100% state funded.

## 4) Recipient and Expenditure Data

a) Total Expenditures

## Aid to the Medically Indigent

Services	FY 82	FY 83*
Hospital	\$55.6	\$41.8
Physician	5.4	6.2
Drugs	0.9	1.0
Nursing Homes	**	1.1
Laboratories	**	0.1
Other	**	0.3
Total	\$61.9	\$50.5

(in millions)

\* State funding for the AMI Program was temporarily suspended from February 1, 1983, to July 1, 1983.

\*\* This service category is included with the other FY 82 figures.

b) Recipients Served

## Aid to the Medically Indigent\*

	FY 80	FY 81	FY 82	FY 83**
AMI	N/A	62,025	88,011	15,343

\* Annual figures, duplicated count.

\*\* Program was suspended from February 1, 1983, to July 1, 1983.

### 5) Recent and Proposed Changes

The AMI Program was suspended from February 1, 1983, through June 30, 1983 but was reinstated for fiscal year 1984.

## II. LIMITED STATE INDIGENT CARE PROGRAMS

### PHARMACEUTICAL ASSISTANCE TO THE AGED AND DISABLED.

Illinois adopted legislation, in its 1984 session, creating a pharmaceutical assistance program for aged and disabled people. The implementation of the program began during the summer of 1985. Residents age 65 and older, with annual incomes below \$12,500 and whose household is liable for payments of property taxes are eligible. The program is tied to the state's tax "circuit breaker" program that provides relief to eligible low-income people who pay property taxes. That is, the person must be certified as eligible under the "circuit breaker" program.

Eligibles must pay an annual fee of \$80 to participant, however no copayment is required for prescriptions. People cannot be eligible for any other public assistance program that covers prescriptions, such as Medicaid.

# INDIANA

## I. STATE INDIGENT CARE PROGRAMS

### A. Hospital Care for the Indigent

The Hospital Care for the Indigent program (HCI) was implemented January 1, 1982. Although the state has the authority to establish standards for eligibility based on income and resources, HCI is a county-only program because the county administers and totally funds it.

Recently the HCI program encountered problems that have rendered the program virtually ineffective. Local governments have been limited in their ability to increase taxes, resulting in some counties denying responsibility for patients under HCI. A survey of 62 percent of the hospitals eligible to receive reimbursement under HCI revealed that fewer than 25 percent of total hospital applications for reimbursement were approved and that only 12 percent were paid on a current basis.

#### 1) Eligibility Standards

##### a) Categorical

The state establishes eligibility standards, which are uniform across counties. The standards are based on Title XIX Medicaid AFDC income standards. The state also develops the application form to be used in determining eligibility.

The county may interpret the eligibility standards in different ways. For example, some counties use the previous 3 months for determining income, some use a 3-month projection, others use the period during hospitalization, and many use other measurements. Thus, although the income standards may be uniform statewide, the various measurements used in determining income render the standards nonuniform across county lines.



To receive reimbursement, a hospital must file an application for each case. The appropriate county receives the application and approves or disapproves it for payment.

## 2) Services and Providers

### a) Services Covered

Treatment must be of an emergency nature and service coverage includes necessary medical and hospital care provided in a hospital. The cost of transportation to the place of treatment can also be reimbursed.

### b) Providers and Settings

Only hospitals, in-hospital physicians, and ambulance companies may receive payments.

## 3) Administration

### a) Responsible Entities

The state establishes the eligibility standards, and the county conducts the eligibility determination and processes providers' claims. The initial application for eligibility, however, is a responsibility of the hospital in order to receive payment.

### b) Funding Source

The program is 100% funded by the county.

### c) Reimbursement Methodology

Payment is the same as for the Title XIX Medicaid program.

## 4) Recipient and Expenditure Data

Not available.

## 5) Recent and Proposed Changes

The Hospital Prospective Payment Study Commission issued its Report to the Legislature December 31, 1984. The report mentions HCI's funding difficulties and recommends that the state assume funding and some administrative responsibility. The legislature did not adopt the

Commission's recommendation during the 1985 legislative session.

#### IV. HEALTH INSURANCE ALTERNATIVES

##### A. Comprehensive Health Insurance and Risk Pool

In 1981, Indiana enacted a comprehensive health insurance law to ensure that its residents would be able to obtain health insurance regardless of the status of their health. The law requires all Indiana insurers, including self-insurers and prepaid health care plans, to participate in an association that offers insurance to persons who have been denied coverage because of their health. The association may not charge more than 150% of the average amount the five largest insurers in the state charge for comparable coverage for standard risk categories. Any net losses are assessed by the association to all members in proportion to their respective shares of total health insurance premiums. Assessments for self-insurers and prepaid health care plans are determined through application of a formula based on claims paid or the value of services provided. Insurers can apply their assessments for losses as a credit against premium taxes, income taxes, corporate income taxes, or similar taxes.

##### 1) Covered Services

Covered services include:

- hospital services, excluding private rooms except when medically necessary, up to 180 days a year;
- professional services of a physician or services rendered by registered or licensed nurses or allied health professionals under a physician's direction;
- the first 20 professional visits per year for the diagnosis and treatment of a mental condition rendered by a physician or by nurses and allied health practitioners working under a physician's direction;
- services of a skilled nursing facility up to 180 days a year;
- services of a home health agency up to 270 days a year;
- use of radium or radioactive materials;
- oxygen;
- anesthetics;
- prostheses, other than dental;
- rental of durable medical equipment;
- diagnostic x-rays and laboratory tests;
- specified types of oral surgery;
- physical therapy and speech therapy services;

- ambulance services; and
- medical supplies required by physicians.

The association's plan has a \$200 deductible, with 20% coinsurance up to a maximum of \$1,000 for individuals and \$2,000 for families.

## 2) Experience

The plan is administered by Mutual of Omaha; it incurred no losses through 1983, but actuaries anticipate a possible loss of \$1.5 million in 1984. Insurers have incurred two assessments to date for start-up costs and cash reserves; the first was for \$100, the second for \$150,000. A third assessment of \$500,000 has been authorized if the association's cash balance falls below \$500,000 this year.

As of April 1984, the association had 3,069 people enrolled, while applications were averaging 150 to 200 per month. The number of enrollees has doubled since the first year of operation.



# IOWA

## I. STATE INDIGENT CARE PROGRAMS

### A. State Papers Program

The State Papers Program is an optional program for the counties, which are legally responsible for providing medical care for their indigent residents. Under the State Papers program, each county is allowed a quota of indigent care patients, who may be treated at a University of Iowa Hospital or Clinic without charge. The state annually appropriates funds to the University of Iowa Hospital for this purpose.

The quota of resident indigents to be treated for each county is determined in the following manner: The ratio of a county's population to the state's population is multiplied by the total number of indigent patients provided care under the State Papers program. The University of Iowa Hospital provides free care to county certified indigents in a number equal to the quota plus 10%. The county must totally reimburse the University of Iowa for the care given over the quota plus 10%. Indigents receiving obstetrical care (including prenatal care), newborn care, orthopedic care, and care for psychiatric hospital referrals are not applied to a county's quota.

#### 1) Eligibility Standards

Vary by county.

#### 2) Services and Providers

All services under the State Papers program must be provided by the University of Iowa Hospital and Clinics. All services available at the University of Iowa Hospital and Clinics are available to the indigent patient, and there are no limitations on those services.

## 3) Administration

a) Responsible Entities

The State Papers program is an optional state-county program, with all counties currently participating. The county establishes the eligibility standards and conducts the eligibility criteria. The state reimburses the University of Iowa through an annual appropriation.

b) Funding Source

The state provides 100% funding for the State Papers Program. If a county exceeds its quota by 10%, the county must reimburse the University of Iowa Hospital for any indigent care rendered beyond that amount.

## 4) Recipient and Expenditure Data

a) Total Expenditures

## State Papers Program\*

	FY 80	FY 81	FY 82	FY 83	FY 84
State Papers	\$19.44	\$20.76	\$22.28	\$24.74	\$24.51

(in millions)

\* Appropriated state funding.

b) Recipients Served

## State Papers Program\*

	FY 81	FY 82	FY 83
State Papers	12,650	12,101	12,163

\*Duplicated count, annual figures.

# KANSAS

## I. STATE INDIGENT CARE PROGRAMS

### A. MEDIKAN

MediKan is the medical component of the state General Assistance program (GA). (MediKan, a state-only program, is not to be confused with the regular Title XIX Medicaid program.)

#### 1) Eligibility Standards

##### a) Categorical

Recipients of General Assistance are automatically eligible, including:

- General Assistance Unrestricted (GAU)
- Transitional General Assistance(TGA)
- Aid to Pregnant Women(APW)
- Refugee GAU
- Refugee TGA.

##### b) Income

An applicant must not have gross earned and/or unearned income exceeding 150% of the appropriate program's standard of need.

GAU recipients who are assigned to a Community Work Experience Program project or are participating in vocation rehabilitation training are eligible for 100% of the standard of need. Otherwise, GAU recipients are eligible for only 80% of the standard of need.

GAU:

- Individual ..... \$363/month
- Family of 4 ..... \$617/month



c) Assets

Applicants may not own nonexempt real or personal property with an aggregate market value in excess of \$1,000. The applicant's home and one auto, up to a value of \$1,000, are excluded.

## 2) Services and Providers

a) Services Covered

Services covered are essentially the same as the categorically needy component of the Title XIX Medicaid program, but the coverage is not as comprehensive:

<u>Includes</u>	<u>Copayments</u>
Physicians' offices visits	\$ 1.00/visit
Inpatient hospital	\$25.00/IP admission
Outpatient hospital	\$10.00/OP visit
Drugs	\$ 1.00/prescription
Laboratory and x-ray	
Life-support DME	
Family planning	
Home- and community-based services	
Community health counties	
Rehabilitation facilities	
Emergency ambulance	

b) Providers and Settings

MediKan covers a broad range of providers and settings:

Acute care hospitals  
 SNFs/ICFs (only if home - and community- based services are not available and coverage is limited to 2 months)  
 Home health agency  
 Physicians  
 Chiropractors  
 Podiatrists  
 Dentists - emergency only  
 Pharmacists  
 Ambulance companies.

## 3) Administration

a) Responsible Entities

The state establishes the eligibility standards, conducts the eligibility determination, and processes providers' claims.

b) Funding Source

The MediKan program is 100% funded by the state.

c) Reimbursement Methodology

For providers other than those listed above, most reimbursement rates are based on profiles (Pharmacy - cost-based prospective rate; durable medical equipment and supplies - fee for service).

## 4) Recipient and Expenditure Data

a) Total Expenditures

## MEDIKAN

	FY 83	FY 84
MediKan	\$25.9	\$15.8

(in millions)

b) Recipients Served

## MEDIKAN\*

	FY 83
GAU	131,854
TGU	28,104
Refugee GAU	12,101
Refugee TGA	909
APW	3,155
Total	176,123

\* Annual, duplicated counts

## 5) Recent and Proposed Changes

- In 1981 GA-Medical Assistance-Only recipients (persons not receiving GA financial Aid, but did qualify for medical services) were made ineligible for medical assistance.
- In 1983 the GA-Medical program was reorganized and given the title of MediKan. Although no study has been conducted to identify the specific causes for the precipitous decline in program expenditures in fiscal year 1984, numerous cost-saving policy changes were implemented. These policy changes include; limiting coverage of elective surgery; implementing primary care networks; adopting a prospective payment system for inpatient hospital payment; and new coverage limitations imposed on many services.



# KENTUCKY

## I. STATE INDIGENT CARE PROGRAMS

Kentucky does not have a state or state-county indigent care program. Some county fiscal courts make small contributions for indigent care, either on a case-by-case basis or to reimburse bad debts and charity care or local hospitals.

In fiscal year 1985, the Kentucky General Assembly appropriated \$7.4 million to the University of Kentucky for charity care and educational expenses. The state does not require documentation.

## II. LIMITED STATE INDIGENT CARE PROGRAMS

### A. Quality Charity Care Trust

On January 27, 1983, the University of Louisville, the state of Kentucky, Jefferson County, the city of Louisville, and Humana Incorporated entered into an agreement that resulted in Humana's leasing the University of Louisville Hospital in return for a 4-year commitment to provide charity care. Another component of the agreement includes support for medical education and research.

The agreement creates the Quality Charity Care Trust to reimburse Humana for hospital care provided to indigents and the medically needy, primarily to the residents of Jefferson County. The Trust is administered by directors appointed by the University of Louisville Board of Trustees. It is financed in the first year by the state of Kentucky (\$14.8 million), Jefferson County (\$2.9 million), and the city of Louisville (\$2.1 million). The governments must increase their annual appropriations to the trust by the lesser of the most recent Consumer Price Index or the rate of increase in their respective tax revenues.

Humana Incorporated must admit all emergency care patients to Humana Hospital University, regardless of their ability to pay. The hospital must also provide medically necessary care for all

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indigents who reside in Jefferson County. An indigent is defined as a person who:

- Is not eligible for Medicare or Medicaid;
- is not covered by a private insurance plan or has exhausted his or her coverage; and
- qualifies for free or reduced care under the Hill-Burton poverty guidelines.

The hospital will be paid for care of indigent and medically needy patients based on its normal charges, minus a 5% discount. Any funds remaining in the Trust at the end of an agreement year will be carried over to the succeeding year. Any surplus remaining in the Trust at the end of a 4-year term will be returned to the governments in the same proportion that they provided funding during that period. The initial duration of the agreement is 4 years. It is renewable automatically for nine subsequent 4-year periods, unless Humana ceases to operate the hospital.

# LOUISIANA

## I. STATE INDIGENT CARE PROGRAMS

### A. State Charity Hospital System

Louisiana has perhaps the most unique program for providing care to the medically indigent. Established in the 1930s, Louisiana finances and operates a network of 9 hospitals located throughout the state. The Charity Hospitals provide necessary hospital-services to the state's indigents.

#### 1) Eligibility Standards

##### a) Categorical

None

##### b) Income

Individual ..... \$500/month

Family of 4 ..... \$800/month

Individuals not deemed medically indigent are admitted as space is available. Such patients are charged under an income-based sliding fee scale.

#### 2) Services and Providers

##### a) Services Covered

All inpatient and outpatient services available at the hospitals are provided to the indigent without restrictions. Ambulatory care services, other than those included in outpatient hospital claims, are not provided.



b) Providers and Settings

Currently nine hospitals are under the Charity Hospital System. They are the only hospitals permitted to receive money under the Charity Hospitals program.

## 3) Administration

a) Responsible Entities

The state Department of Health and Home Resources has overall administrative responsibility, including establishing eligibility standards, funding the program, and preparing budget requests for the legislature. Eligibility determinations are conducted by the hospitals.

b) Funding Source

The program is 100% state funded.

c) Reimbursement Methodology

Hospitals are directly funded by the state thus, no processing of claims or reimbursement methodology is necessary.

## 4) Recipient and Expenditure Data

a) Total Expenditures

In fiscal year 1983-84, the state spent \$157 million for the medically indigent through its Charity Hospitals system. This figure does not include expenses for teaching or for care rendered to the nonindigent.

# MAINE

## I. STATE INDIGENT CARE PROGRAMS

### A. General Assistance - Medical

Under the General Assistance program (GA-M), recipients receive nonelective medical treatment when deemed medically necessary by a physician. The administration of the program is split into two components: self-administered programs - under the organized municipalities; and a state-administered program for the unorganized or unincorporated townships.

#### 1) Eligibility Standards

##### a) Categorical

Both components of GA-M extend medically necessary services to a recipient.

##### b) Income

- i) Organized Municipalities: Income standards vary by municipality.
- ii) Unorganized Townships (state-administered): Varies by an individual's or family's circumstances and living arrangements.

##### c) Assets

- i) Organized Municipalities: Varies by county.
- ii) Unorganized Townships (state-administered):

Individual ..... \$250/month  
Two or more persons ... \$500/month

Exclusions from assets include the home, one auto, personal effects, and income-producing property.

## 2) Services and Providers

Both components of GA-M provide only those services deemed medically necessary by a physician.

## 3) Administration

### a) Responsible Entities

- i) Organized Municipalities: The municipality establishes the eligibility standards, conducts the eligibility determination and processes providers' claims.
- ii) Unorganized Townships: The state establishes the eligibility standards, conducts the eligibility determination and processes providers' claims.

### b) Funding Source

- i) Organized Municipalities: The state reimburses the locality for 90% of the entire GA-M program costs (including the medical costs) that exceed 0.03% of the municipality's property valuation. The municipality must provide funding for the 0.03% plus 10% of the remaining costs.
- ii) Unorganized Townships: The state funds 100% of the program costs.

### c) Reimbursement Methodology

Fee-for-service for most providers.

## 4) Recipient and Expenditure Data

### a) Total Expenditures

In fiscal year 1983, the state and municipalities spent a total of \$420,000 for medical costs under the GA-M program.

### b) Recipients Served

Not available.



## II. LIMITED STATE INDIGENT CARE PROGRAMS

### A. Medical Eye Care Program

All legal residents of Maine whose annual incomes do not exceed 80% of the state's median income, adjusted for family size (family of one - \$7,932; family of two - \$10,368; family of three - \$12,816), and who meet specified medical criteria are eligible to participate in the medical eye care program. Eligible individuals must have a significant eye disorder that, if untreated, may progress to blindness and a visual acuity after correction of 20/70 in the better eye. Coverage is provided for eye examinations, medication, hospitalization, surgery, transportation, laser therapy, and eyeglasses. Reimbursement to providers is made on the basis of Medicaid fee schedules. Seventy-five percent of the eligible recipients are over 50 years old. The number of persons participating in the program has declined from 7,829 in FY 1981 to 4,258 in FY 1983. Expenditures, which were \$275,000 in FY 1981, declined slightly to \$274,000 in FY 1983.

### B. Pharmaceutical Assistance for Aged Persons

Maine operates a pharmaceutical assistance program for legal residents who are 62 or older, who are ineligible for Supplemental Security Income, and whose household incomes do not exceed \$7,400 per year for two or more persons or \$6,200 per year for one person. A \$2.00 copayment is levied for each prescription filled; coverage is provided for only seven categories of drugs used to treat heart conditions, high blood pressure, and diabetes. The number of recipients has remained stable at 23,000 from FY 1981 through FY 1983. Expenditures have risen from \$909,000 for FY 1981 to \$1,405,000 for FY 1983. Reimbursement to providers is the lower of maximum allowable costs, estimated acquisition costs, or average wholesale price plus a \$3.20 dispensing fee.

## III. INDIGENT CARE PROVISIONS UNDER RATE SETTING

During FY 1985, Maine proposes to implement a prospective hospital rate-setting system for all payers except Medicare. State officials plan to apply for a Medicare waiver but will

continue to implement the system whether or not they receive a waiver. The commission reviews each hospital's budget and adjusts its rates to ensure that it receives sufficient revenues to meet its financial requirements, including an allowance for bad debts and charity care. The first year's allowance for bad debts and charity care is based on each hospital's average costs for bad debts and charity care for the preceding 3 years, plus the amount that each hospital was reimbursed in the previous year from the catastrophic health insurance program. Inpatient hospital costs from the budget for the catastrophic health insurance program were transferred to the hospital rate-setting commission at the beginning of FY 1985.

The rate-setting commission does not distinguish between charity care and bad debts for purposes of reimbursement and does not specify eligibility criteria for free or reduced-cost care.

#### IV. HEALTH INSURANCE ALTERNATIVES

##### A. Catastrophic Health Insurance

In 1974, Maine became one of the first states to enact a program designed to protect residents from the costs of catastrophic health care with the passage of LD 2535 (22 MSRA 3282).

To be eligible for participation in the Catastrophic Illness Program, applicants must be U.S. citizens or permanent residents of the United States and residents of Maine. They may not reside in any public institution and cannot be eligible for Medicaid. Applicants must pay 30% of their costs of medical care from their net income and must apply 10% of their net worth in excess of \$20,000 for medical treatment. Net worth is defined as the market value of all real and personal property, less any encumbrances and liabilities, including all cashable and noncashable assets. Cashable assets include cash on hand, checking accounts, savings or credit union accounts, government bonds, stocks, annuities, cash value of life insurance, certificates of deposit, notes or mortgages that are salable or redeemable upon demand, money from insurance settlements, sales of any property, inheritances, or awards. In addition, all health insurance benefits or liability benefits from third-party payers must be fully applied to medical care costs. Applicants pay a deductible of \$7,000. {Note: Between 1975 and 1981, income eligibility criteria were (1) 20% of medical care costs from net income; (2) 10% of net worth in excess of \$20,000; and (3) \$1,000 deductible.}

1) Covered Services

Covered services include:

- nonpsychiatric physicians' services;
- ambulance services to the nearest hospital or medical facility;
- medical supplies or equipment;
- laboratory and x-ray services;
- physical therapy services;
- ophthalmology; and
- some care in a skilled nursing facility.

Until May 1984, both hospital inpatient and outpatient services were also covered. Under current policy, these costs may be applied to the \$1,000 deductible, but they are not covered by the program. According to program administrators, payment for inpatient and outpatient costs has not been eliminated. Rather, these costs are now covered under Maine's hospital prospective payment system, which included Medicaid and other third-party insurance carriers but not Medicare.

2) Experience

From FY 1975 to FY 1980, both expenditures and numbers of persons served by the Catastrophic Illness Program rose dramatically, as indicated in the following tables.

Table I

CIP Expenditures: Fiscal Years 1975 to 1980

Fiscal Year	Costs	Increase	Percent Change
1975	\$ 457,195	--	--
1976	663,240	\$ 206,045	45%
1977	807,116	143,876	22%
1978	1,418,432	611,316	76%
1979	2,346,369	927,937	65%
1980	4,167,602	1,821,233	78%

Source: Maine Department of Human Services



Table II  
CIP Recipients\*: FY 1975 to 1980

Fiscal Year	Recipients*	Increase	Percent Change
1975	365	--	--
1976	816	451	123.5%
1977	840	24	2.9%
1978	1,093	253	30.1%
1979	2,242	1,149	105.1%
1980	2,557	315	14.0%

Source: Maine Department of Human Services

\* Figures reflect only those individuals who were eligible for at least a month of CIP benefits. Because benefit periods do not conform to calendar or fiscal years, totals include a duplicate count; that is, some individuals were counted in 2 or more successive years.

The National Center for Health Services Research analyzed the program experiences during the period of 1975 to 1980. That study, which was released in May 1983, concluded that the program essentially functioned as a public health insurance program for those without private insurance and disproportionately served poor, unemployed, and uninsured adults aged 18 to 44 instead of those for whom the program was intended -- people with catastrophic expenses who had less than adequate private insurance coverage. This outcome, according to NCHSR, resulted from the structure and administration of the program, which contained no incentives to obtain private health insurance coverage. In addition, inflation had two effects: It increased the costs of services and reduced the real dollar amount of the deductible.

In July 1981, criteria for financial eligibility were revised: the amount of payment recipients were required to make increased from 20% to 30% of net income, and the deductible was increased from \$1,000 to \$7,000. These changes resulted in a dramatic decline in the number of people eligible and in the program's expenditures.

Table III

## CIP Expenditures and Recipients: FY 81-84

Year	Recipients	Expenditures
1981	2,516	\$5,200,687
1982	N/A	N/A
1983	386	\$2,945,750
1984	385	\$2,330,742

As a result of these changes, the program's focus has shifted so that it probably more nearly fulfills its original legislative intent -- providing protection against catastrophic expenses to persons whose private health insurance coverage is inadequate. By the same token, though, coverage is no longer available to those who had benefited from the program in its earlier years -- poor, unemployed, and uninsured young adults.

Recent Changes

L.D. 2309 eliminated payments for inpatient and outpatient hospital services under the catastrophic illness program, effective May 1984. The law requires the Hospital Finance Commission to consider costs previously covered by the catastrophic illness program in setting rates under the state's new all-payer rate setting system. The bill also provides for payments to counties for catastrophic illness programs for the interim period between the elimination of the hospital services from the catastrophic illness program and the inclusion of these costs in all payer rate settings.





# MARYLAND

## I. STATE INDIGENT CARE PROGRAMS

### A. State-Only Medicaid

The state of Maryland's indigent care program is administered by the agency responsible for the Title XIX Medicaid program. Thus, the policies of both programs are very similar. The State-only Medicaid program is totally state funded.

#### 1) Eligibility Standards

##### a) Categorical

General Public Assistance recipients are automatically eligible. Other groups covered include Title XIX Medicaid ineligible spouses and parents in an assistance unit with Title XIX eligible persons and persons aged 21 to 65 who are not technically eligible for Title XIX and are not in a Title XIX assistance unit.

##### b) Income

Individual .....	\$267/month
Family of 2 .....	\$309/month

##### c) Assets

Individual .....	\$2,500
Family of 2 .....	\$2,600

Exclusions include the home, one auto, income producing property, and personal effects.

## 2) Services and Providers

### a) Services Covered

The same services are covered as those covered by the categorically needy component of the Title XIX Medicaid program. The only difference is that State-only Medicaid recipients must pay a \$0.50 copayment on drugs.

### b) Providers and Settings

Providers must be certified Title XIX Medicaid providers.

## 3) Administration

### a) Responsible Entities

The State-only Medicaid Program is administered by the state (i.e., the state establishes the eligibility standards, determines the services covered, and processes providers' claims); however, individual counties and the city of Baltimore conduct the eligibility determination.

### b) Funding Source

The State-only Medicaid Program is 100% funded by the state.

### c) Reimbursement Methodology

Providers are reimbursed on the following basis: Hospital rates are set by the Maryland Health Service Cost Review Commission; rates for home health, nursing homes, medical equipment, supplies, drugs, and, eyeglasses are cost based; and individual providers are reimbursed under a fee schedule.

## 4) Recipient and Expenditure Data

a) Total Expenditures

## State-only Medicaid Expenditures

Services	FY 81	FY 82	FY 83	FY 84
IP hospital	\$49.1	\$51.8	\$60.5	\$58.7
OP hospital	9.7	11.3	13.7	13.7
Physicians	7.1	8.0	9.6	10.0
Pharmacy	3.5	4.5	5.8	6.1
Nursing home	0.8	0.7	0.8	0.6
Dental	0.9	0.8	0.7	0.5
Home health	0.2	0.4	0.6	0.6
Other	1.2	1.4	1.7	1.5
Total	\$72.5	\$78.8	\$93.5	\$91.7

(in millions)

b) Recipients Served

## State-only Medicaid Recipients\*

	FY 81	FY 82	FY 83	FY 84
State Medicaid	55,325	56,969	59,078	54,734

\*Duplicated, annual count

## II. LIMITED STATE INDIGENT CARE PROGRAMS

A. Pharmacy Assistance Program

Maryland enacted a program to provide eligible persons with financial assistance in paying for pharmaceutical products. Persons eligible for Medicaid are not eligible to participate in this program. Income eligibility criteria range from \$5,100 for a 1-person household to \$10,150 for a household of ten; the program also sets maximum allowable assests ranging from \$2,500 to \$3,400. Recipients must make a copayment of \$1.00 per prescription. Expenditures have steadily increased since the program's inception, but the rate of increase has been



fairly moderate. In FY 80, the first year of operation, expenditures were \$1,128,000; FY 84 expenditures were \$3,494,591. The average enrollment during that time increased from 7,344 to 11,370, while the average cost per prescription increased from \$8.37 to \$14.88.

### III. INDIGENT CARE PROVISIONS UNDER RATE SETTING

The Maryland Hospital Rate-Setting Commission was established in 1971, but it did not actually begin setting rates until 1977. At that time, the state received a waiver from the federal government that permitted it to become the first "all payer" rate-setting state through the inclusion of Medicare and Medicaid in the system.

Under Maryland's system, all payers share in the costs of bad debts and charity care, which, according to the commission's data, averaged 5.7% of hospitals' gross revenues in 1983. The table below shows bad debts and charity care reimbursement to hospitals for FY 1981 to 1983.

Maryland Bad Debt/Charity Care Payments

FY	Bad Debts and Charity Care Reimbursement	Percentage of Gross Revenues	Number of Hospitals
1981	\$ 80,000,000	5.2	55
1982	103,000,000	5.7	55
1983	120,000,000	5.7	57

Reimbursement to hospitals for charity care and bad debts ranged from 1.73% of gross revenues to 12.32%. Urban hospitals received the bulk of funds; Maryland's 17 rural hospitals received 11% of the total reimbursement for bad debts and charity care.

Three different systems of regulating rates are currently in effect in Maryland, but all three systems use the same method for calculating reimbursement for bad debts and charity care. Hospitals receive the lesser of: (1) the previous year's actual costs of bad debts and charity care; (2) whatever they request; or (3) whatever the commission's analysis determines is reasonable.

The commission's analysis of reasonableness takes 20 variables into account, the most important of which is the percentage of Medicaid revenues. Hospitals with high volumes of Medicaid recipients usually receive higher reimbursement for bad debts and charity care. The commission has not set standard eligibility requirements for receiving free or reduced-price care, nor has it prescribed mandatory collection efforts. Charity care and bad debts are calculated separately under this system but combined for purposes of reimbursement, thus blurring the distinction between them. Hill-Burton costs may be included in costs that hospitals claim for reimbursement under bad debts and charity care.

### Evaluation

The National Health Law Program's evaluation of Maryland's reimbursement system noted that a detailed examination of the system's effects has not been conducted. It did note, as have other studies, that Maryland's prospective rate setting appears to be successful in several respects. For the last 8 years, the cost per hospital-day rose less than the national average, as did the cost per hospital admission. In addition, the program cited a commission survey in which 27% of hospitals reported that they experienced a significant improvement in revenue as the result of reimbursement for bad debts and charity care.





# MASSACHUSETTS

## I. STATE INDIGENT CARE PROGRAMS

### A. General Relief

General Relief is a state-funded and -administered program that provides ambulatory care to recipients. Inpatient hospital care is to be provided by hospitals that are regulated under the rate setting law. (See section III Indigent Care Provisions under Rate Setting.)

#### 1) Eligibility Standards

##### a) Categorical

General Relief recipients are automatically eligible. Eligibility for General Relief is extended to adults with a mental or physical disability, adults over 44 with 20 hours or less of work per week or no work experience in the preceding 6 months, SSI applicants awaiting payments, ex-convicts (for 2 months only), half-way house residents, persons caring full-time for an incapacitated relative eligible for Medicaid, and full-time students under 19 living with unemployed parents.

##### b) Income

Individual .....	\$225/month
Family of 2 .....	\$290/month
Family of 4 .....	\$420/month

##### c) Assets

Individual .....	\$250/month
Family of 4 .....	\$500/month

The home, auto, household and personal effects are excluded.

## 2) Services and Providers

### a) Services Covered

The Massachusetts General Relief program covers only ambulatory services. These services include:

- Physician office visits
- Community health center services
- Dental care
- Podiatry (foot care)
- Laboratory tests
- X-rays
- Private duty nursing
- Psychological testing
- Durable medical equipment
- Full pharmacy services (medications)
- Transportation to covered services
- Eye exams and eyeglasses
- Hearing aids
- Rehabilitation center services
- Physical, occupational, and speech/language therapy
- Speech and hearing center services and
- Family planning services.

### b) Providers and Settings

All services are reimbursable in community settings only. To receive reimbursement, the provider must be a participant in the Title XIX Medicaid program.

## 3) Administration

### a) Responsible Entities

The General Relief program is a uniform statewide program with the state establishing eligibility standards, conducting the eligibility determination, and processing providers' claims.

### b) Funding Source

The General Relief program is 100% funded by the state.

c) Reimbursement Methodology

The providers (all nonhospital) are reimbursed under the Title XIX Medicaid fee-for-service system.

## 4) Recipient and Expenditure Data

a) Total Expenditures

## General Relief Medical Expenditures

Service	FY 80	FY 81	FY 82	FY 83	FY 84
Physician	\$1.06	\$1.30	\$1.60	N/A	\$2.10
Dental	1.07	1.15	1.15	N/A	1.88
Drugs	0.83	1.20	1.58	N/A	3.04
Other	0.30	0.36	0.42	N/A	1.58
Total	\$3.26	\$4.01	\$4.75	\$7.16	\$8.60

(in millions)

b) Recipients Served

Not available.

## 5) Recent and Proposed Changes

As of November 1984, Massachusetts added the following covered ambulatory services:

- All medications
- Podiatry
- Rehabilitation
- Transportation
- Family planning
- Private duty nursing
- Psychological testing and
- Mental health services (in conjunction with the Department of Mental Health).



### III. INDIGENT CARE PROVISIONS UNDER RATE SETTING

Massachusetts enacted a mandatory rate-setting law (Chapter 372) that went into effect October 1, 1982. The state has a Medicare-waiver that will remain in effect until September 1985. The rate setting system is based on hospital-specific revenue ceilings, called MAC or maximum allowable costs, which are derived from the hospital's 1981 costs. These costs are adjusted for changes in volume, inflation, and certain exceptions, including capital costs.

The Massachusetts law was designed to have two different mechanisms for reimbursement of uncompensated care. The first system was in effect from October 1982 until October 1984; basically it perpetuated the traditional method of paying for uncompensated care by shifting costs to Blue Cross. In addition to the implicit subsidies for uncompensated care through continuation of pre-Chapter 372 rates, both Medicare and Medicaid made some contributions. Under the waiver, Medicare was permitted to share in some costs of charity care but not bad debts. Medicare reimburses hospitals for its proportionate share of charity care up to 1.4% of total hospital payments. For example, if Massachusetts hospitals receive \$5 billion in reimbursement and Medicare's share of the market is 40%, then Medicare will pay for \$28 million in free care ( $\$5 \text{ billion} \times 40\% \times 1.4\%$ ).

Medicaid provides limited funding for charity care under Chapter 372; it will pay its proportionate share for free care rendered in hospitals that derive at least 68% of their revenue from Medicare, Medicaid, bad debts, free care, and state and local subsidies. Only four hospitals qualify under this provision, one of which is Boston City Hospital. If Medicaid's share of the market in these hospitals is 30%, then it will pay for 30% of the costs of free care.

In October 1984, the basic method of paying for uncompensated care changed, but Medicare's and Medicaid's formulas remained unchanged. Under the new system, the cost of charity care and bad debts are made explicit, rather than remaining implicit, as they did under the previous system. These now explicit costs are built into a hospital's maximum allowable cost ceiling, and charged-based payers and Blue Cross are reimbursed up to specified limits. A hospital is reimbursed for all uncompensated costs unless charges to Blue Cross and private payers needed to generate revenue sufficient to pay for them exceed 125% of the hospital's maximum allowable payment level.

Under this system, Blue Cross, which serves approximately 50% of the market, will receive a 9% discount in FY 1985 that declines to 7.5% in FY 1986 and FY 1987. Medicare and Medicaid



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also receive discounts.

Massachusetts defines free care as "a revenue deduction associated with the provision of services to patients who have reasonably been deemed financially unable to pay, in whole or in part, for their care." Bad debt is defined as "an account receivable based on services furnished to any patient which (1) is regarded as uncollectible, following reasonable collection efforts; (2) is charged as a credit loss; (3) is not the obligation of any governmental unit or of the federal government or any agency thereof; and (4) is not free care."

The Health Care Financing Administration within the federal Department of Health and Human Services required the state to use 200% of federal poverty guidelines as the benchmark for determining eligibility for receiving free care and to obtain a financial statement from patients. Hospitals have also been required to institute collection policies.



# MICHIGAN

## I. STATE INDIGENT CARE PROGRAMS

### A. Resident County Hospitalization Program

Each county is required to provide hospitalization for its indigent residents; however, the state offers the Resident County Hospitalization (RCH) program to counties. In 1983, 62 out of 83 counties participated in the state reimbursement system whereby the state processes providers' claims and pays \$100 per day of hospitalization. The 21 counties that do not participate in RCH do not receive any state funding for inpatient hospitalization costs.

The following information pertains to participating counties unless otherwise noted.

#### 1) Eligibility Standards

Vary by county.

#### 2) Services and Providers

##### a) Services Covered

RCH covers inpatient hospital services only, including physician and dental services during the hospital stay. Any other services connected with an inpatient stay may be paid by counties, depending on county policy. Authorization of the local office is required before service is administered.

##### b) Providers and Settings

The RCH program is restricted to hospitals enrolled in the Title XIX Medicaid program. Services delivered at a county-owned hospital do not qualify for any state reimbursement.

## 3) Administration

a) Responsible Entities

The county establishes the eligibility standards and conducts the eligibility determination. The state processes providers' claims and bills the county for costs over \$100 per hospital day.

b) Funding Source

For participating counties, the state pays approximately 80% of the RCH program costs. The percent varies from year to year, but the state payment stays constant at \$100 per day. The county is responsible for paying any amount over \$100.

c) Reimbursement Methodology

For participating counties, inpatient hospital payments are based on costs, while physicians and dentists are paid on a fee-for-service basis.

## 4) Recipient and Expenditure Data

a) Total Expenditures

## Resident County Hospitalization Expenditures\*

	FY 80	FY 81	FY 82	FY 83
IP hospital	\$13.29	\$23.78	\$36.03	\$46.72
Physician	0.55	1.08	1.98	2.59
Other	0.02	0.03	0.34	0.14
Total	\$13.87	\$24.90	\$38.36	\$49.46

(in millions)

\* State expenditures only

b) Recipients Served

## Resident County Hospitalization Program\*

	FY 80	FY 81	FY 82	FY 83
RCH	6,139	8,370	9,871	13,185

\* Duplicated, monthly figure



### 5) Recent and Proposed Changes

Before October 1, 1980, county hospitalization was totally administered and financed by the county. After October 1, 1980, the state began paying claims at Title XIX Medicaid rates for inpatient and physician services, with the county making a predetermined daily payment back to the state.

On October 1, 1982, the county became responsible for total payment of the inpatient stay, less the \$100 per day that the state provides.

On January 1, 1983, counties were permitted the option of making provider payments again, at their own reimbursement rates. Once a county opts out of the RCH program, however, it cannot begin state payment again.

Starting in 1985 the state will begin to use the Title XIX Medicaid DRG system for reimbursement of inpatient hospitalization, and will retain the \$100 of state financial liability for each IP hospital day.

## B. General Assistance-Medical

The General Assistance-Medical (GA-M) program is a uniform state-administered program that provides ambulatory medical care to General Assistance recipients.

### 1) Eligibility Standards

#### a) Categorical

General Assistance recipients are automatically eligible for medical services if they are not eligible for Title XIX Medicaid.

#### b) Income

150% of the need standard.

c) Assets

Available assets are limited to \$50, with the following assets excluded: the homestead, one automobile up to \$1,500 equity value, and assets essential to employment.

2) Services and Providers

a) Services Covered

Services provided under GA-M are limited to ambulatory care only, including physician office visits, outpatient hospital visits, pharmaceuticals, laboratory tests and x-rays, psychiatric care, dental care, home health, physical therapy, eyeglasses, medical supplies, and hearing aids.

All services (except emergencies in an emergency room) must be prior authorized. Coverage of dentures and hearing aids is limited to employment-related needs. All recipients must pay the Title XIX Medicaid copayment: \$0.50 for prescription drugs, \$3.00 for dental services, \$2.00 for podiatrists, \$1.00 for chiropractors, \$3.00 for hearing aids, and \$2.00 for eyeglasses.

b) Providers and Settings

Providers must be enrolled in Medicaid. Eligible providers include physicians, dentists, home health agencies, labs, ambulances, family planning clinics, outpatient clinics and emergency rooms of hospitals, pharmacies, hearing aid and speech centers, medical supplies, optical companies, and optometrists.

3) Administration

a) Responsible Entities

The GA-M program is a state-administered program. The state establishes eligibility standards, conducts the eligibility determination and processes providers' claims.

b) Funding Source

The GA-M program is 100% state funded.

c) Reimbursement Methodology

Reimbursement to providers is on a fee-for-service basis.

## 4) Recipient and Expenditure Data

## General Assistance Medical Expenditures

	FY 80	FY 81	FY 82	FY 83	FY 84
GAM	\$ 7.32	\$12.39	\$16.02	\$18.24	\$20.76

(in millions)

In fiscal year 1983, expenditures broke down as follows:

<u>Service</u>	<u>Percent of FY 83 Expenditures</u>
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Physicians .....	32%
Prescribed drugs .....	27
OP hospital .....	24
Lab and x-ray .....	10
Other .....	7
	<u>100%</u>

b) Recipients Served

## General Assistance Medical Recipients\*

	FY 80	FY 81	FY 82	FY 83
GAM	10,269	16,307	20,138	25,404

\* Monthly figure, duplicated count

## 5) Recent and Proposed Changes

Before January 1, 1982, the applicant and those for whom the applicant was responsible (spouse for spouse, parent for child) living in the same dwelling unit were included in the GA group. Under the new household policy, generally all persons related by blood, marriage, or adoption living in the same dwelling unit are included in the GA group.

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As of June 1, 1984, medical coverage is available for all Michigan Community Service Corps, Michigan Conservation Corps, Michigan Youth Corps, or a grant diversion demonstration project.

C. Nonresidents Hospitalization Program

The Nonresident Hospitalization program is designed to provide medical services to nonresidents traveling through the state and migrant laborers ineligible for federal medical assistance. The mandatory program is jointly administered by the state and the counties. The county establishes the eligibility criteria, certifies applicants' eligibility, determines which services will be provided, and directly reimburses the providers. The state covers 100% of the funding. In 1983, \$303,000 was spent to provide care to 92 recipients (84 migrants and 8 nonresidents).



# MINNESOTA

## I. STATE INDIGENT CARE PROGRAMS

### A. General Assistance - Medical Care

Counties must participate in the General Assistance - Medical Care program.

#### 1) Eligibility Standards

##### a) Categorical

Recipients of General Assistance are automatically eligible; other individuals may become eligible under the spenddown provision.

##### b) Income

Individual .....	\$301/month
Family of 4 .....	\$556/month

##### c) Assets

Individual .....	\$1,000
Family of 4 .....	\$1,000

#### 2) Services and Providers

##### a) Services Covered

The General Assistance - Medical Care program covers the following services:

- IP hospital
- OP hospital
- Prescription drugs
- Physician
- Dental

- Medical transportation
- Insulin supplies
- Hearing aids
- Prosthetic devices
- Tests and x-rays.

b) Providers and Settings

Any licensed provider of a covered service is eligible to participate.

3) Administration

a) Responsible Entities

The GA-Medical Care program is jointly administered by the state and the counties. The state establishes the eligibility standards and offers the option of reimbursing providers for counties. Ninety percent of the counties elect to have the state process the claims. The county conducts the eligibility determination.

b) Funding Source

Overall, the state finances 90% of the GA-Medical Care program costs, and the counties are responsible for the remaining 10%. However, each county's costs vary directly with the number of resident recipients. The payback system is identical to the one used under the Title XIX Medicaid program.

c) Reimbursement Methodology

Reimbursement is the same as that for Title XIX Medicaid, except reasonable changes are based on the 50th percentile of 1978 profiles.

## 4) Recipient and Expenditure Data

a) Total Expenditures

## General Assistance Medical Care

Service	FY 80	FY 81	FY 82	FY 83
IP hospital	\$26.4	\$32.0	\$26.6	\$21.9
OP hospital	2.8	3.5	2.9	3.2
Physician	5.7	8.0	5.8	4.2
Dental	1.6	2.6	1.3	0.9
Pharmacy	1.5	1.9	1.4	1.4
Other	2.8	4.2	0.8	0.6
Total	\$40.8	\$52.2	\$38.8	\$32.2

(in millions)

b) Recipients Served

## General Assistance Medical Care\*

	FY 80	FY 81	FY 82	FY 83
GAMC	10,215	12,944	10,819	9,961

\* Monthly average, duplicated counts.

## 5) Recent and Proposed Changes

Major changes were instituted in 1981. The legislature dropped coverage of home health, outpatient nursing, optometric services, family planning, medical supplies, chiropractor services, and podiatrist services.

Payments to providers were reduced during fiscal years 1981, 1982, 1983, and 1984. The legislature permitted reductions in payment up to 45% for inpatient and outpatient hospital care for diagnosis of chemical dependency or mental illness, 35% for other hospital care, and 25% for all other services. For FY 1985, these percentages are reduced to 30, 20, and 10, respectively.

In 1984, the legislature added coverage of insulin supplies, hearing aids, prosthetic devices, and lab and x-ray services.

## II. LIMITED STATE INDIGENT CARE PROGRAMS

### The University Hospital Papers Program

The University of Minnesota Hospital receives an appropriation from the legislature to provide care to indigent persons referred to it by county welfare departments. The intent of the program, called the University Hospital Papers Program, is to provide care at the university hospital to people who are ineligible for other publicly funded health care programs. The hospital is authorized to spend up to \$2 million each year on the program.

Counties set the eligibility criteria, which are rather informal and vary considerably across counties. Counties must pay 40% of hospital charges for eligible participants up to a maximum of \$4,400, while the hospital uses its appropriation to pay 60% of charges up to \$11,000. The fund pays 100% of charges in excess of \$11,000. Recipients are not required to contribute to the cost of their care.

To date, the university has not used the entire amount appropriated to it for indigent care. Program administrators at the hospital report that imposition of strict eligibility criteria by some counties, who must share in the program's costs and certify eligible persons to the hospital, probably explains why some of its funds go unspent.

## IV. HEALTH INSURANCE ALTERNATIVES

### A. Catastrophic Health Insurance

From 1976 to 1981, Minnesota operated a catastrophic health insurance program designed to provide financial assistance to full-time residents who had catastrophic medical expenses. The Catastrophic Health Expense Protection Program (CHEPP) which was administered by the Department of Public Welfare, had two components: (1) CHEPP-I in FY 81 provided assistance for ordinary hospital and medical expenses; and (2) CHEPP-II



provided qualified nursing home care for those under age 65.

Gross household income was used to determine eligibility; it included the federal adjusted gross income plus any nontaxable income of an eligible person and his dependents age 23 and older. To qualify for CHEPP-I, an applicant had to incur qualified expenses within any 12-month period for himself or members of his family that exceeded 20% of the household income up to \$15,000; plus 25% of the household income between \$15,000 and \$25,000; and 30% of the household income in excess of \$25,000. After eligibility was established, the state paid 90% of the costs of covered services, and the recipient paid the remaining 10%. Originally, eligible persons were required to make out-of-pocket expenditures of 40% of income up to \$15,000, 50% of income between \$15,000 and \$25,000, and 60% of income over \$25,000, in addition to paying a deductible of \$2,500.

### 1) Covered Services

Covered services included:

- Hospital services;
- Professional services for the diagnosis and treatment of illness or injury (other than outpatient mental or dental care);
- Drugs prescribed by a physician;
- 120 days in a skilled nursing facility, if Medicaid certified;
- Home health services, if Medicaid certified;
- Use of ionizing radiation or radioisotopes for therapeutic or diagnostic services;
- Oxygen;
- Anesthetics;
- Nondental prostheses;
- Rental or purchase of durable medical equipment;
- Oral surgery (under specified conditions);
- X-rays and laboratory tests;
- Physical therapy;
- Ambulance transportation to the nearest qualified health care institution; and
- Mileage costs for transportation to kidney dialysis treatment facilities.

Nursing home assistance under CHEPP-II was limited to persons under age 65 who had been a nursing home resident for at least 36 months and who had incurred expenses exceeding 20% of gross household income for the year preceding eligibility.

### 2) Experience

During the first year of CHEPP-I, both expenditures and numbers of participants grew much more slowly than anticipated. In FY 1978, \$8 million was appropriated for the program, but only

\$270,897 was expended on behalf of 114 participants. When financial eligibility criteria were relaxed; the \$2,500 deductible eliminated, and hospitals became aware of the program, however, participation grew much more rapidly. For FY 1982, welfare analysts projected that expenditures would outstrip the program's rapid growth. Eligibility criteria that provided no incentive for people to obtain catastrophic health insurance also contributed to the program's rapid growth. In addition, elimination of the deductible created incentives for recipients to obtain benefits from CHEPP-I rather than Medicaid.

CHEPP-II was always a small program. Its restrictive eligibility criteria meant that only a very small number of people could participate in the program. For example, from FY 78 through FY 81, an average of 12 people participated in CHEPP-II each year. The program's expenditures during this time totaled \$204,049.

Both CHEPP programs were eliminated in May 1981, when the governor vetoed a bill that contained continuing appropriations for the program. In his veto message, Governor Quie cited three reasons for vetoing the bill:

1. The rapid growth in program costs was excessive in light of tight state budgetary constraints and would require significant cuts in other state programs.
2. The program lacked a test to determine what assets an applicant might have.
3. The program lacked incentives for individuals to purchase catastrophic health insurance.

#### B. Comprehensive Health Insurance and Risk Pool

In 1976, Minnesota passed a comprehensive health insurance act (Chapter 296, Minnesota Laws of 1976) that made several significant changes in the state's insurance laws. It defined "qualified" insurance plans as including individual or group policies, HMO contracts, or any combination of such plans. The minimum benefit level is identical to the covered services listed under the Catastrophic Health Expense Protection program.

Three levels of qualified plans all offer the same medical plans. The key distinguishing feature among qualified plans is the amount of the deductible. Number One (low-option) plans require a deductible of no more than \$1,000, Number Two plans require a \$500 deductible, and Number Three (high-option) plans require an annual deductible of no more than \$150. Qualified plans must also comply with certain minimum standards.

Employers, including the state government, who employ more than



10 persons and who offer health insurance benefits, are required to offer a Number two qualified plan, and employers of more than 100 people who offer health insurance benefits must offer an HMO option. (The law does not require insurers to offer health insurance benefits, but it does regulate types of plans that employers must offer if they do provide health insurance benefits.) Employers failing to comply with these provisions will have their employee health benefit costs disallowed as an income tax deduction.

State residents not covered by provisions of the act can obtain coverage directly from health insurers, who are required to offer all three qualified plans to eligible applicants.

### Risk Pool

Another provision of the 1976 act created the Minnesota Comprehensive Health Association (MCHA) to which all licensed insurers, HMOs, and fraternal organizations must belong. The purpose of the association is to provide coverage to persons unable to obtain insurance from other sources. The association is required to offer Plans One and Two but not Plan Three. The amount charged for premiums is limited to 125% of the average of the rates charged by the five insurers having the largest number of Minnesota residents in that specific type of qualified plan.

The association is governed by a seven-member board of directors elected by members, and each member's vote is weighted in proportion to their volume of accident and health insurance, HMO, or self-insurance in Minnesota. Selection of board members must be approved by the Commissioner of Insurance. Daily administration of the association is by a "writing carrier" selected by the association for a 3-year period and approved by the Commissioner.

Although all groups issuing insurance must belong to the association, only some insurers are responsible for any losses suffered by the plan. Insurers responsible for losses are called "contributing members" and are defined as those companies that offer, sell, issue, or renew policies or contracts of accident and health insurance. Blue Cross and self-insurers are not subject to an assessment for losses. When the plan suffers a loss (as it has every year since its creation), the association levies an assessment upon contributing members to cover the losses and administrative expenses of the writing carrier. The amount levied is equal to the total amount of the assessment times the ratio of each contributing member's total premium to the total premiums received by all contributing members. Losses experienced by the association are may be absorbed by the state, however, as contributing members may offset their losses directly by taking

credits against their state premium taxes.

The number of persons participating in the comprehensive health insurance association, premium income, and volume of paid claims have grown steadily, if not rapidly, since its inception, as shown in the following table. While the association continues to sustain substantial losses, its loss ratio has declined each year. The following table summarizes the program's experiences in the last three and three-fourths years.

Comprehensive Health Insurance Association  
(Risk Pool)

	1981	1982	1983	1984***
Participants	2,918	4,350	6,043	8,015
Total Premiums*	\$1.31	\$2.33	\$4.08	\$5.12
Claims Paid*	\$2.85	\$4.51	\$6.08	\$7.78
Loss Ratio**	236%	211%	187%	151%

\* In millions

\*\* Loss ratio is Percentage of Claims Incurred to Earned Premium

\*\*\* As of October 1, 1984.



# MISSISSIPPI

## I. STATE INDIGENT CARE PROGRAMS

The state of Mississippi funds medical care services to the indigent under three programs: the State Hospital Commission; the Charity Hospital System; and an annual appropriation for indigent care to the University of Mississippi Hospital and Medical Center. Only the first two programs are profiled here.

### A. State Hospital Commission

The State Hospital Commission partially reimburses approved hospitals that provide inpatient care to county indigents. Based on the county's population, the State Hospital Commission allocates a county maximum limit on the amount of state funds that may be used to reimburse hospitals for charity care.

#### 1) Eligibility Standards

Each hospital participating in the program establishes its own eligibility standards, based on a scale establishing ability to pay. The state neither establishes nor requires approval of eligibility standards.

#### 2) Services and Providers

##### a) Services Covered

Medically necessary inpatient hospital services are provided.

##### b) Providers and Settings

Only hospitals may receive reimbursement under the program. To be eligible for reimbursement, the hospital must submit an application that contains a copy of the most recent cost report, less

depreciation.

3) Administration

a) Responsible Entities

The hospital establishes the eligibility criteria and conducts the eligibility determination. The state processes providers' claims.

b) Funding Source

The State Hospital Commission's Charity Care program is 100% state funded.

c) Reimbursement Methodology

The state is authorized by the legislature to pay up to \$100 per day or 75% of the costs. Recently, reimbursement has been limited to \$65 to \$75 per day.

4) Recipient and Expenditure Data

a) Total Expenditures

From July 1983 through June 1984, the State Hospital Commission reimbursed over 70 hospitals a total of \$2.3 million for care rendered to the medically indigent.

b) Recipients Served

From July 1983 through June 1984, a total of 5,669 patients (duplicated count) received hospital care under the charity care program administered by the State Hospital Commission.

B. Charity Hospital System

The state of Mississippi operates three charity hospitals: Matty Hersee Hospital in Meridian; Kuhn Memorial State Hospital in Vicksburg; and South Mississippi State Hospital in Laurel. The hospitals also serve as teaching hospitals for various health professions. The legislature annually appropriates

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funds to the hospitals to aid in the financing of medical treatment for the indigent. The hospitals also treat Medicare and Medicaid patients. A specific breakdown of funds used to finance care for the indigent is not available.





# MISSOURI

## I. STATE INDIGENT CARE PROGRAMS

### A. General Relief-Medical

#### 1) Eligibility Standards

##### a) Categorical

General Relief maintenance (cash) recipients are automatically eligible for GR-Medical.

##### b) Income

Individual .....	\$181/month
Family of 2 .....	\$256/month

##### c) Assets

The limit on available resources is \$1,000 for one person and \$2,000 for two persons. Limit on total property is \$20,500. Applicants may not transfer property that would result in eligibility without receiving the fair market value for it.

##### d) Other

Applicants must apply for SSI and be unable to work as the result of mental or physical disability expected to last at least 90 days or must be needed at home to care for a disabled person.

## 2) Services and Providers

### a) Services Covered

Services covered under the GR-Medical program include:

- Limited inpatient hospital
- Outpatient hospital
- Physician visits
- Prescription drugs
- Lab tests and x-rays
- Emergency ambulance service
- Orthopedic devices
- Prosthetic devices
- Durable medical equipment
- Home health care
- Ambulatory surgical care.

### b) Providers and Settings

Providers must be enrolled in the Title XIX Medicaid program to receive reimbursement under the GR-Medical program.

## 3) Administration

### a) Responsible Entities

Under the GR-Medical program, the state establishes the eligibility standards, conducts the eligibility determination, and processes providers' claims.

### b) Funding Source

The GR-Medical program is 100% funded by the state.

### c) Reimbursement Methodology

Reimbursement under the GR-Medical program is similar to that under the Title XIX Medicaid program. Inpatient hospital services are reimbursed on a prospective basis; however, the rate that any specific hospital will receive is either the rate in effect when the hospital entered the Medicaid program or the rate in effect when the recipient was admitted, whichever is lower. Payments to nursing homes are also on a prospective basis. Other providers are reimbursed under a fee schedule.

## 4) Recipient and Expenditure Data

a) Total Expenditures

## General Relief-Medical Expenditures

	FY 80	FY 81	FY 82	FY 83
GR-Med	\$11.4	\$19.9	\$17.9	\$14.7

(in millions)

b) Recipients Served

## General Relief - Medical Recipients\*

	FY 81	FY 82	FY 83
GR-Med	6,140	4,921	5,116

\*Monthly figure, duplicated count.

## 5) Recent and Proposed Changes

Several services were longer provided to General Relief recipients as of July 1981: hearing aids and audiology services, optical services, podiatry, dental services and dentures, family planning, and EPSDT.

In July 1981, school attendance, for 18-21 year olds, was removed as a reason for being considered unemployable.

In 1982, coverage of hospitalization for General Relief was prorated at 50% of the maximum allowable charge. In April 1982, the standard for length of disability was changed from 30 days to 90 days (that is, the applicant must have a disability expected to last at least 90 days to be considered unemployable).

## II. LIMITED STATE INDIGENT CARE PROGRAMS

### A. Blind Pension Program

Missouri provides state-funded medical services to Missouri residents who are at least 18 years old, whose vision is less than 5/200 with or without glasses, and whose sponsor or parents are unable to provide full support. Income is not limited; however, recipients must not have assets, excluding homes and furnishings, in excess of \$20,000. Recipients must participate in vision review if recommended, undergo corrective eye surgery if recommended, and cannot transfer property to become eligible. In addition, recipients cannot be inmates of public institutions and must be 65 or older if residing in a mental institution.

Services under this program are the same as those provided categorically eligible Medicaid recipients, and reimbursement policies follow Medicaid's. Expenditures were \$504,027 in FY 1981 and rose to \$1,015,379 in FY 1983. In FY 1981, 676 persons were served; in FY 1984, the number of persons served was 1,282.

### B. High-Risk Maternity and Child Care Programs

Missouri has a state-funded high-risk maternity and child care program, which was appropriated \$3,000,000 for FY 1985. This appropriation has remained constant since FY 1981. Income eligibility is based on a sliding scale adjusted for family size and the average cost of conditions treated.

Services covered by Medicaid are not covered by this program, but the program does pay for services not covered by Medicaid for Medicaid recipients. Services provided include: (1) transportation services for women and infants; (2) care for high-risk pregnant women; (3) services to infants with respiratory distress syndrome; and (4) ultrasound screenings.

For FY 1985, Missouri projects that it will provide 50 transportation services, care for 200 high-risk pregnant women, provide services for 100 infants with respiratory distress, and perform 1,000 ultrasound. Costs are reimbursed on the basis of usual, customary or reasonable screens, except that a \$40,000 payment limit is placed on services provided to premature infants.



### C. Other Limited Indigent Care Programs

Missouri has several disease-specific, limited programs. In FY 1985, the Sickle Cell Anemia program was appropriated \$90,000, down from approximately \$200,000 in FY 1981. The program expects to provide screenings for 18,000 people and treatment for 30 people in FY 1985. The appropriation for the Cystic Fibrosis program is the same as that for the Sickle Cell Anemia program; the program expects to serve 200 people in FY 1985. The Tuberculosis program was appropriated \$432,944 in FY 1981; that appropriation was reduced to \$244,700 in FY 1985. Fifty inpatient days and 34,000 weeks of outpatient TB services will be provided.

The following appropriations were made from state general revenue funds for indigent care in FY 1985:

State Chest Hospital .....	\$2,698,420
Ellis Fishel Cancer Hospital .....	3,388,015
Public Hospital Subsidy .....	250,000

The public hospital subsidy is available for any public hospital; it provides a subsidy of up to 10% of the difference between costs and revenue. The subsidy is not specifically targeted to indigent care. The appropriation has declined in recent years; it was \$5 million in FY 1981 and \$2.5 million in FY 1982.



# MONTANA

## I. STATE INDIGENT CARE PROGRAMS

### A. State-Administered General Relief

Montana counties are authorized to provide for the care and maintenance of the indigent sick. Recently the state instituted an optional state program in which the state administers the General Relief program and provides some funding. Unless otherwise noted, the following profile describes those under the state option. As of July 1, 1984, 12 of 56 counties elected to participate.

All other counties administer and fund their own programs. The state, which must approve a county's General Relief plan, uses the services covered under the Medicaid program as a guide during review. Thus, a county that covers significantly fewer services than the Title XIX Medicaid program may not receive approval.

#### 1) Eligibility Standards

##### a) Categorical

General Relief recipients automatically qualify for medical services.

##### b) Income

Individual .....	\$305/month
Family of 2 .....	\$371/month
Family of 4 .....	\$425/month

##### c) Assets

Nonliquid resources must not exceed \$1,000.

The home, a vehicle not to exceed \$1,500 equity value, and personal effects are excluded.

d) Other

Any applicant must participate in the county work program unless exempt.

2) Services and Providers

a) Services Covered

The covered services are the same as the categorically needy components of the Title XIX Medicaid program, but prior authorization is required except in emergencies.

b) Providers and Settings

Participation is restricted to Title XIX Medicaid providers, who must accept payment as payment in full.

3) Administration

a) Responsible Entities

The state establishes the eligibility standards and processes providers' claims. Counties are responsible for conducting the eligibility determination.

b) Funding Source

Under state-administered General Relief, the county provides the equivalent of a 13.5-mill levy on property tax. The state funds in full any expenses beyond the 13.5 mill levy incurred by the county's indigent. The effect is that the state funds approximately 50% of the cost of medical care for indigents.

c) Reimbursement Methodology

The method of reimbursement is the same as that used for Medicaid. Reimbursement for hospitals is cost based and retrospective, home health care payment is cost based and prospective, and all other payment for providers is based on a fee schedule.



## 4) Recipient and Expenditure Data

a) Total Expenditures

## State Administered General Relief\*

	FY 80	FY 81	FY 82	FY 83
S-GR	\$4.1	\$3.6	\$3.4	\$4.4

(in millions)

\* State and local funding of GR-Medical expenditures.

b) Recipients Served

Not available

## 5) Recent and Proposed Changes

As of July 1, 1983, the state assumed administration of the General Relief programs in 11 counties. Those counties not under state administration make their own rules, subject to the state's approval of the plan. Before the state assumed administration of the program, the state mandated the rules.

## IV. HEALTH INSURANCE ALTERNATIVES

Risk Pool

The Montana legislature adopted a law in their 1985 session mandating the creation of a risk pool that offers health insurance to persons denied coverage in the private market.



# NEBRASKA

## I. STATE INDIGENT CARE PROGRAMS

Nebraska does not have a state indigent care program.

County General Assistance programs provide emergency medical care to recipients. Benefits and eligibility criteria vary by county. Another program (optional for counties) is the People in Transit-County program, which provides medical care to indigent nonresidents traveling through the state. Both programs are administered and funded by the counties.

## II. LIMITED STATE INDIGENT CARE PROGRAMS

### A. State Disability Program - Medical

The State Disability program provides aid (including medical assistance) to needy persons who have a disability expected to last at least 6 months but less than the 12 months required to be eligible for the federal Supplemental Security Income program.

#### 1) Eligibility Standards

The State Disability program uses SSI program criteria, but the disability must be at least 6 months.

## 2) Services and Providers

The services provided under the State Disability program are the same as those provided under the categorically needy component of the Title XIX Medicaid Program.

## 3) Administration

a) Responsible Entities

The State Disability program (including the medical component) is a state program. The state establishes eligibility standards, conducts the eligibility determination, and processes providers' claims.

## 4) Recipient and Expenditure Data

a) Total Expenditures

## State Disability - Medical Expenditures

	FY 80	FY 81	FY 82	FY 83
SD-Med	\$1.2	\$0.68	N/A	\$0.97

(in millions)

b) Recipients Served

## State Disability - Medical Recipients\*

	FY 80	FY 81	FY 82	FY 83
SD-Med	2,124	1,044	N/A	1,004

\* Unduplicated count, annual figures

## IV. HEALTH INSURANCE ALTERNATIVES

Risk Pool

The Nebraska legislature adopted a law in their 1985 session mandating the creation of a risk pool that offers health insurance to persons denied coverage in the private market.



# NEVADA

## I. STATE INDIGENT CARE PROGRAMS

### A. Supplemental Fund for Medical Assistance to the Indigent

In 1985, Nevada adopted AB 422 (Chapter 629, Laws of 1985) which requires counties to create a "fund for medical assistance to indigent persons" and creates the Supplemental Fund for Medical Assistance to the Indigent. Both programs are totally funded by the counties but the latter is administered by a state board of trustees.

Under the county fund for medical assistance to indigent persons, each county board of commissioners is responsible for establishing their own eligibility standards, setting payment rates, and conducting the eligibility determination. By July 1, 1985 counties must create a "fund for medical assistance to indigent persons" to be used for reimbursement of any unpaid charges for medical care furnished to an indigent person who falls sick in the county. Claims for payment must be approved by the board of county commissioners.

The county fund is financed by levying an ad valorem tax of 3 cents on each \$100 of assessed valuation upon all taxable property in the county. (Of the 3 cents tax per \$100 of assessed property, three-tenths of one cent per \$100 of assessed property is credited to the state Supplemental Fund for Assistance to Indigent Persons.) Subsequent levies will vary if any counties have unencumbered monies remaining at the end of the fiscal year. Nonetheless, a counties' proposed allocation to their "fund for medical assistance to indigent persons" must increase by at least 4.5 percent over the previous fiscal years allocation.

The new legislation also creates a Supplemental Fund for Assistance to Indigent Persons. The Supplemental Fund is financed by counties remitting three-tenths of one cent per \$100 of assessed property from their indigent care ad valorem tax. The Supplemental Fund is capped at \$1 million and administered by a newly created board of trustees. The

Supplemental Fund is a county catastrophic illness program, but with a key limitation. Reimbursement from the Supplemental Fund is limited to unpaid charges for hospital care in excess of \$25,000 to any one person who has been certified as indigent by the county commissioners. The Supplemental Fund however, is only available to those counties whose indigent care expenditures will exceed the amount available collected by the ad valorem tax. Counties may begin applying for supplemental funds after 90 percent of the amount available has been spent and it is expected all available funds will be expended before the fiscal year is over.

B. Fund for Hospital Care to Indigent Persons

In July 1983, the Nevada legislature enacted a bill designed to reduce the financial burden imposed upon counties when indigents incur sizable medical bills as the result of accidents. The bill created the Fund for Hospital Care to Indigent Persons and authorized the fund to raise revenues for fiscal year 1983-84 by imposing a levy of \$.0075 per \$100.00 of assessed valuation on all taxable property in each county. Maximum revenues authorized by the legislature for FY 1983-84 were \$1,022,000.

The fund alleviates counties' financial burdens by reimbursing hospitals and health care providers directly for costs incurred by indigents in excess of \$4,000 resulting from accidents. The first \$1,000 of hospital charges is not reimbursable, and the next \$3,000 in hospital charges is reimbursed by the county in which the accident occurred if the injured person is not a Nevada resident. If the individual is a resident of Nevada, then the indigent's county of residence is responsible for reimbursement. Stop-loss insurance exempts the fund from most but not all costs incurred by individuals in excess of \$50,000.

During the fund's first 6 months in operation, it received 151 potential claims totaling \$724,235, which included expenses not reimbursable by the fund, such as the first \$4,000 of hospital charges. Program officials anticipate that the fund will end its first year of operation without incurring a deficit.

# **NEW HAMPSHIRE**

## **I. STATE INDIGENT CARE PROGRAMS**

New Hampshire does not have a state or state-county indigent care program. City, town or county-level Direct Relief programs may reimburse providers for emergency medical care in extreme cases, but the benefits and eligibility criteria vary by county.





# NEW JERSEY

## I. STATE INDIGENT CARE PROGRAMS

### A. General Assistance - State Match Medical Program

State law requires all municipalities to provide a general assistance program, and all programs must apply uniform eligibility and benefit standards. Most but not all counties participate in the optional State Match program. In 1984, 560 out of 567 municipalities participated in the State Match program which covers 99% of the municipal caseload. Such broad participation results in statewide uniform eligibility and benefits standards.

#### 1) Eligibility Standards

##### a) Categorical

General Assistance recipients are automatically eligible. The individual must not be eligible for any other program and, if employable, must be willing to work and participate in workfare.

##### b) Income

Employable .....	\$119/month
Unemployable .....	\$178/month

##### c) Assets

Applicants may not have any assets.

#### 2) Services and Providers

Municipalities in the State Match program provide services similar to the Title XIX Medicaid program.

## 3) Administration

a) Responsible Entities

The state establishes eligibility standards for those municipalities participating in the General Assistance-State Match Medical program. Municipalities conduct the eligibility determination and process providers' claims.

b) Funding Source

For municipalities participating in the State Match program, the state provides 75% of the expenditures. Nonparticipating municipalities totally fund their programs.

c) Reimbursement Methodology

The program uses the same method of reimbursement as that used by the Title XIX Medicaid program (DRGs) for inpatient hospital care.

## 4) Recipient and Expenditure Data

a) Total Expenditures

## General Assistance State Match-Medical\*

	FY 80	FY 81	FY 82	FY 83
Hospital	\$12.09	\$10.26	\$11.91	\$13.68
Nursing Home	0.98	1.23	1.35	1.62
Other Medical	1.88	1.91	1.89	2.19
Total	\$14.95	\$13.40	\$15.15	\$17.49

(in millions)

\* Total medical expenditures of state and municipalities for State Match program.

b) Recipients Served

## General Assistance State Match-Medical\*

	FY 80	FY 81	FY 82	FY 83
GA-SM	25,632	25,632	26,004	29,551

\*Duplicated annual figures.

B. AFDC Nonfederal - Medical

## 1) Eligibility Standards

a) Categorical

The parents in families with children living with both natural or adoptive parents when the parents are not eligible under federal criteria.

b) Income

Family of 4 ..... \$276/month

c) Assets

Family of 4 ..... Up to \$1,000

## 2) Services and Providers

The program covers the same services and providers as the Title XIX Medicaid program.

## 3) Administration

a) Responsible Entities

The AFDC Nonfederal-Medical program is mandatory. The state establishes eligibility standards and processes providers' claims. The counties conduct the eligibility determination.

b) Funding Source

The AFDC Nonfederal-Medical program is 100% state funded.

c) Reimbursement Methodology

The method of reimbursing providers is the same as that used for the Title XIX Medicaid program.

## 4) Recipient and Expenditure Data

a) Total Expenditures

## AFDC Nonfederal-Medical

	FY 80	FY 81	FY 82	FY 83	FY 84*
AFDC-NF	\$3.62	\$4.07	\$3.65	\$4.11	\$4.75

(in millions)

\* Estimated

Although a breakdown of payments by service and providers is not available, the March 1984 payments were distributed as follows:

<u>Service</u>	<u>Percent of Expenditures</u>
Inpatient hospital	62%
Outpatient hospital	10
Physician	10
Drugs	9
Dentist	5
Other	4
	<u>100%</u>

b) Recipients Served

## AFDC NF-Medical\*

	FY 81	FY 82	FY 83	FY 84**
AFDC-NF	2,509	2,069	2,142	2,124

\*Unduplicated monthly count

\*\* Estimate



C. Medical Assistance for the Aged

The state of New Jersey also has a Medical Assistance for the Aged program (an old Kerr-Mills program), but the program is being phased out and enrollment of new clients ended June 30, 1982. The caseload currently eligible at that time was grandfathered into the program for life if they continue to meet the eligibility criteria and were not eligible for any other federally funded medical care program. The program provides the same services as the categorically needy component of the Title XIX Medicaid program. Medical Assistance for the Aged is totally state administered and funded.

## Medical Assistance for the Aged

	FY 80	FY 81	FY 82	FY 82	FY 84
Recipients	-	514	683	649	488*
Expenditures	\$0.8	\$1.8	\$2.8	\$3.0	\$2.6*

Monthly, unduplicated recipient count; Expenditures in millions

\* Estimated

## II. LIMITED STATE INDIGENT CARE PROGRAMS

A. Pharmaceutical Assistance for Aged and Disabled Persons

New Jersey operates a program that provides pharmaceutical assistance for aged and disabled persons who meet income eligibility criteria. Married couples whose household incomes are below \$15,000 and single people whose incomes do not exceed \$12,000 are eligible to participate. The program reimburses pharmacies for prescription drugs dispensed to eligible persons. Recipients must make a \$2 copayment for each prescription dispensed.

## P.A.A.D.

	FY 83	FY 84
Recipients*	280,730	270,852
Expenditures**	\$57.0	\$70.3

\* Annual, duplicated count

\*\* In millions

## III. INDIGENT CARE PROVISIONS UNDER RATE SETTING

Under New Jersey's all-payer, DRG-based, rate setting system, the costs of providing uncompensated care, which covers both charity care and bad debts, are included in the rates reimbursed by all payers. Both Medicare and Medicaid also share in these costs.

An "uncompensated care factor" is included in the determination of each hospital's preliminary cost base, which is adjusted for several factors and then used to prospectively determine each hospital's reimbursement. The uncompensated care factor is calculated separately for each hospital and reflects the hospital's own ratio of uncompensated care to its gross revenues. The hospital's reimbursement rates are then increased by this factor.

Although all payers share in all costs, some payers qualify for a differential based on "quantifiable economic benefits rendered to an institution or to the health care delivery system taken as a whole." Medicare receives a 2.66% differential, Medicaid a 2.65% discount, and Blue Cross a 6.18% reduction. Charge-based payers absorb the difference.

"Uncompensated care costs" that may be included as reimbursable costs include: (1) services to "individuals unable to pay for them for reasons of indigency"; and (2) bad debts "provided adequate recovery procedures are followed and the account is at least 120 days old." In FY 1983, New Jersey hospitals received at least \$190 million in reimbursement for uncompensated care, approximately 5 to 8% of total reimbursement.

The eligibility standard hospitals use to determine whether a patient qualifies for free care is the income level used in the state's General Assistance program. Hospitals may also use the Hill-Burton free care test, which is 100% of the Community

Services Administration poverty level. Patients must be screened before admission to determine whether they are eligible for free care. Grants or appropriations from local governments are subtracted from the costs of uncompensated care.

On January 2, 1985, the Health Care Financing Administration granted an extension of New Jersey's Medicare waiver through December 1987. The new waiver requires the state to reimburse the federal government for any Medicare payments in excess of payments that would have been made under Medicare's prospective pricing system (DRGs). The outpatient portion of the waiver was temporarily extended to give HCFA an opportunity to review additional data. State officials must supply the data by March 1985, and HCFA has agreed to make a final decision on outpatient services within 45 days of receiving the information.

### Evaluation

The National Health Law program's evaluation of New Jersey's provisions for reimbursing the costs of charity care reported that New Jersey's reimbursement for uncompensated care is quite generous. Approximately 5 to 8% of all reimbursement is for uncompensated care, and the burden is spread fairly equitably among all payers. In addition, no evidence of reduced access has been found since the system was implemented in 1980.





# NEW MEXICO

## I. STATE INDIGENT CARE PROGRAMS

### A. Indigent Hospital Claims Act

The Indigent Hospital Claims Act mandates a county program to provide necessary medical care to indigent residents of New Mexico. A county may adopt a sales tax, not to exceed 0.25% if passed by the electorate. Eleven of 33 counties have indigent care funds or a county hospital. The legislation carries no penalties for noncompliance.

The County of Bernalillo is exempted from the Indigent Hospital Claims Act and maintains its own county hospital located in Albuquerque. The state provides funds (\$950,000 in FY 84) to the Bernalillo County hospital for care provided to out-of-county residents.

#### 1) Eligibility Standards

State law provides a broad definition of medical indigency: a person who can normally support himself and his dependents on present income and available liquid assets but who is unable to pay the cost of ambulance transportation or hospital care. However, the county commission may pass a resolution excluding from eligibility any person whose income together with his spouse's total an amount 50% greater than the state per capita income.

#### 2) Services and Providers

Services include inpatient hospital care and ambulance transportation.

## 3) Administration

Although the state sets broad eligibility guidelines, counties may establish other guidelines. The county conducts the eligibility determination and processes providers' claims. Counties provide all funds, with the exception of Bernalillo County, which receives a state appropriation for its county hospital.

## II. LIMITED STATE INDIGENT CARE PROGRAMS

A. Special Medical Need Program for the Seriously Ill

This program is a state-administered program (that is, the state establishes the eligibility standards, conducts the eligibility determination, processes providers' claims, and totally funds the program).

The program is for individuals who are over age 65, blind, or disabled and ineligible for Title XIX Medicaid. An applicant must be certified by a physician to be seriously ill such that lack of treatment may lead to death. The income maximums are \$385 per month for an individual and \$579 for a couple.

Services provided under this program are virtually the same as those covered by Title XIX Medicaid except for skilled nursing facilities or intermediate care facilities, which are not provided. Inpatient hospital coverage is limited to 5 days per admission.

## SMNPSI

	FY 81	FY 82	FY 83	FY 84
Recipients*	71	-	115	113
Expenditures	\$107,030	\$165,137	\$204,450	\$339,875

\* Unduplicated monthly count

# NEW YORK

## I. STATE INDIGENT CARE PROGRAMS

### A. State-Only Medicaid

#### 1) Eligibility Standards

##### a) Categorical

Recipients of Home Relief (the state/county general assistance program) are automatically eligible for State-Only Medicaid. Persons who are eligible for Home Relief but do not want a cash grant may also be eligible. Persons not eligible under Title XIX and who have hospital bills which exceed the lesser of 25% of their net income or the difference between their net income and the public assistance standard of need may be eligible. These individuals are referred to as Medical Assistance-HR related and Medical Assistance-Catastrophic, respectively, and funding is state/local, 50%/50%.

##### b) Income

Individual .....	\$207-\$371/month
Family of 4 .....	\$454-\$676/month

Limit varies by need and location of residence.

##### c) Assets

###### i) Under the MA-HR Program:

Individual .....	\$1,000
Family of 4 .....	\$1,000

###### ii) Under the MA-Catastrophic program:

Individual .....	\$2,850
Family of 4 .....	\$5,500

One automobile and the home are excluded.

## 2) Services and Providers

The services covered and the providers that are reimbursed are the same as those under the categorically needy component of the Title XIX Medicaid program.

## 3) Administration

### a) Responsible Entities

The State-Only Medicaid program is jointly administered by the state and county governments. The state establishes the eligibility standards, and the state fiscal intermediary processes providers' claims. The counties conduct the eligibility determination.

### b) Funding Source

The funding of the State-Only Medicaid program is 50% state and 50% county.

### c) Reimbursement Methodology

Reimbursement to providers is made on the following basis: Hospital payments are established under the New York Prospective Hospital Reimbursement Methodology; outpatient hospital, lab services, and physicians' fees are based on a fee schedule; and nursing home services are cost based and prospective.

## 4) Recipient and Expenditure Data

### a) Total Expenditures

In calendar year 1983, the total expenditures for State-Only Medicaid were \$533.5 million.

### b) Recipients Served

A count of recipients is not available.



### III. INDIGENT CARE PROVISIONS UNDER RATE SETTING

New York implemented an all-payer rate setting system in January 1983 after receiving a waiver from the Health Care Financing Administration permitting Medicare and Medicaid to participate in the system and contribute to the cost of uncompensated care, with the stipulation that the rate of increase in Medicare expenditures be kept 1.5% below the national average rate of increase in Medicare costs.

New York's reimbursement system contains two mechanisms for financing indigent care. The costs of certain bad debts and charity care are built into inpatient revenue caps along with inpatient expenses computed by peer groups, capital expenses, an inflation factor, and an allowable cost for retirement of non-capital debt. Private hospitals also contribute to a pool for financially distressed hospitals and to a transition pool designed to assist voluntary nonprofit and private proprietary hospitals adversely affected by the new rate setting system. Once the Department of Health determines each hospital's inpatient revenue cap, it then establishes gross charges sufficient to generate the inpatient revenue permitted by the revenue cap.

In addition to reimbursement for charity care and bad debts built into the inpatient revenue cap, New York also has a second reimbursement mechanism for indigent care that consists of regional funding pools. Their purpose is to provide pools for hospitals' bad debt and charity care costs and to distribute those costs more equitably among hospitals. Separate pools exist for major public hospitals (the public sector) and for voluntary, proprietary, and nonmajor public hospitals (the private sector). In FY 1983, the total amount of funds available for distribution was 2% of the total reimbursable inpatient costs for FY 1981, the base year. In 1984, funds equaled 3% of base year costs; they will equal 4% in 1985. Costs are adjusted for inflation each year.

The pools are funded by a surcharge on hospital reimbursements paid by third-party payers (including Medicare, Medicaid, and Blue Cross) and by a surcharge on hospital bills for self-pay patients. The surcharge is 2% in 1983, 3% in 1984, and 5% in 1985 for all payers.

Funds from the pools are distributed differently to public- and private-sector hospitals. Private-sector hospitals receive higher reimbursement for bad debts and charity care. According to the National Health Law program, voluntary hospitals received between \$0.35 and \$0.48 on each bad debt/charity care dollar spent in 1984, while public hospitals received only

\$0.06 for each dollar of care provided. This inequity will worsen to the point where private-sector hospitals will be paid for 80% of their uncompensated care costs, while public-sector hospitals will be reimbursed for only 10% of their uncompensated care costs. The premise underlying higher payments to private hospitals is that public hospitals have access (if not actual financial support) from local governments through tax levies.

The pools provide a finite amount of money for charity care and bad debts rather than open-ended reimbursement for all costs hospitals incur in providing care. This limit creates incentives for hospitals to reduce charity care, because they will receive higher reimbursement for care if they care for fewer patients. To counteract the incentive, the system contains a provision that penalizes hospitals and regions that decrease the proportion of charity care by more than 2% by shifting funds to hospitals and regions that have been provided proportionally more care. Hospitals providing free or reduced-charge care in compliance with their Hill-Burton obligation are permitted to count these costs as charity care and can receive reimbursement for them through the charity care pools. It appears that this provision enables hospitals to be reimbursed twice for care rendered to Hill-Burton patients: once through the Hill-Burton obligation and again through the regional pools.

The New York system defines bad debt and charity care separately but combines them for the reimbursement in the pool. No definite eligibility standards for qualifying for free care have been set; hospitals determine whether people are qualified to receive free care according to their own criteria.

The National Health Law program's evaluation of the New York system reported that the rate setting system made available more funds than ever before for charity care and bad debts. The report noted an inequitable disbursement of funds from regional pools for public-sector hospitals. The evaluation asserted that it was unlikely local governments, especially New York City, would provide additional funds for charity care as the intent of the pools was to fund charity care.

# **NORTH CAROLINA**

## **I. STATE INDIGENT CARE PROGRAMS**

North Carolina does not have a state or state-county indigent care program. Some county general assistance programs may reimburse providers for medical care, but the benefits and eligibility criteria vary by county.





# NORTH DAKOTA

## I. STATE INDIGENT CARE PROGRAMS

North Dakota does not have a state or state-county indigent care program. The state and county-administered general assistance program may reimburse providers for emergency medical care, but the benefits and eligibility criteria vary by county.

## II. LIMITED STATE INDIGENT CARE PROGRAMS

### A. Remedial Blind Program

North Dakota operates a very limited program for persons who are suffering from eye conditions that may lead to blindness, or conditions that can be corrected to prevent blindness but that do not meet Medicaid's definitions of blindness. The program serves about six people a year, and its FY 1985 budget is approximately \$10,000.

## IV. HEALTH INSURANCE ALTERNATIVES

### A. Comprehensive Health Insurance and Risk Pools

In 1981, North Dakota passed a law requiring all insurers in the state having an annual premium income of at least \$100,000 to participate in a comprehensive health association. The association's purpose is to provide comprehensive health insurance to residents who have been denied coverage on account of poor health or who may have been able to purchase only

restrictive health insurance coverage.

The law also requires insurers to disseminate information regarding the plan's availability, provides for the designation of a lead carrier, and limits administrative expenses to 12.5% of premium income. A 1983 amendment restricted premiums levels to 135% of the average premium rates charged by the five largest insurers in the state for individual plans.

### 1) Covered Services

Covered services, to be reimbursed at 100% of usual, customary or reasonable fees, after deductibles have been paid, include:

- Hospital services;
- Professional services for the diagnosis or treatment of injuries, illness, or conditions, other than outpatient mental or dental services, that are rendered by a physician or at a physician's direction;
- Use of radium or other radioactive materials;
- Oxygen;
- Anesthetics;
- Diagnostic x-rays and laboratory tests;
- Services of a physical therapist; and
- Transportation provided by a licensed ambulance service.

Chiropractic services may be included at the policyholder's option.

The following services are specifically excluded from coverage:

- Drugs requiring a physician's prescription;
- Services of a nursing home;
- Home health services;
- Physicians' home and office calls;
- Prostheses;
- Rental or purchase of durable medical equipment;
- The first \$20 of diagnostic x-rays and laboratory charges in each 14-day period;
- Oral surgery;
- Any care covered by workers' compensation or automobile insurance policies;
- Charges for treatment for cosmetic purposes other than to repair an injury or birth defect;
- Charges for travel provided by other than a licensed ambulance service or travel provided to a facility that is not the closest one qualified to treat the condition;
- Private room charges unless prescribed as medically necessary;
- That part of a charge for services or articles rendered or prescribed by a physician or other health care practitioner that exceeds the prevailing charge in the locality where the service is provided;

- 
- Charges for services rendered that are not within an individual's authorized scope of practice; and
  - Care that is primarily for custodial or domiciliary purposes and that is not reimbursed by Medicare.

Members of the association have the option of offering subscribers policies with varying deductibles (\$150, \$500, and \$1,000). All plans must pay 80% of charges with an individual stop loss of \$3,000 and a lifetime maximum benefit of \$250,000. The plan has a 6-month preexisting condition clause.

## 2) Experience

Limited information is available concerning the plan as it has been in operation only a few years. The plan incurred \$103,400 in claims and sustained \$22,800 in losses in FY 1982. In FY 1983, the plan had a much greater volume of claims -- \$345,918 -- and reduced its losses slightly to \$20,994.





# OHIO

## I. STATE INDIGENT CARE PROGRAMS

### A. General Relief-Medical

The General Relief program is not uniform statewide, for although GR (and its medical component) is mandated by law and certain services are required, counties may limit the amount and duration of these services. Counties may also add services at their choice.

#### 1) Eligibility Standards

##### a) Categorical

The recipients of General Relief are automatically eligible.

##### b) Income

No absolute standards apply to GR-Medical rather, they are computed in the payment level for GR.

##### c) Assets

The total equity value of all countable real property, personal property, and liquid assets owned by the assistance group cannot exceed \$1,000. The home in which the recipient resides and one vehicle with an equity value of less than \$1,200 are excluded.

## 2) Services and Providers

a) Services Covered

Mandated services include inpatient and outpatient hospital care, physician services, and prescription drugs.

A limitation of 30 inpatient hospital days per recipient per year applies. However, counties can impose more restrictive limitations than the mandated services.

## 3) Administration

a) Responsible Entities

GR-Medical is jointly administered by the state and county. The state establishes eligibility criteria and counties certify an applicant's eligibility and reimburse providers.

b) Funding Source

The state share is 75%, the county share 25%. Low-income counties can receive a greater share as determined by a state formula.

## 4) Recipient and Expenditure Data

a) Total Expenditures

## GR-Medical Expenditures

	FY 81	FY 82	FY 83	FY 84
GR-M	\$62.2	\$87.0	\$130.7	\$151.5

(in millions)

b) Recipients Served

## GR-Medical Recipients\*

	FY 80	FY 81	FY 82	FY 83
Recipients	21,741	28,166	43,997	48,863**

\* Duplicated count, averages per month

\*\* Estimate based on 9-month average

The survey response indicated GR-Medical recipients tend to be single employable adults, childless couples, and families ineligible for AFDC.

## II. LIMITED STATE INDIGENT CARE PROGRAMS

A. Adult Emergency Assistance

Ohio used to provide Adult Emergency Assistance (AEA) for individuals meeting the financial eligibility criteria and who require services for an emergent need. A service was provided if a delay in treatment would result in a threat or of loss life. In fiscal year 1981 \$10.7 million was spent under AEA and \$11.6 million was spent in 1982. In 1983 the eligibilty standards for the program were tightened resulting in a reduction in AEA expenditures (to \$1.2 million in 1983 and a negligible amount in 1984). Some of the former emergency recipients became eligible for the regular GR-Medical program.





# OKLAHOMA

## I. STATE INDIGENT CARE PROGRAMS

### A. Oklahoma Indigent Health Care Program

In 1984 the Oklahoma legislature enacted HB 1802, the Oklahoma Indigent Care Act. The act creates an optional state program that is jointly funded and administered by the state and participating counties. Hospitals meeting the state requirements for participation, shall receive state and county payments. For hospitals to participate, the county that the hospital is located must also participate.

#### Counties

For a county to participate, it must meet several requirements. First, it must create a county indigent health care trust board and a county indigent health care fund. The fund must be financed by an ad valorem tax levy 3 1/2 mills of assessed property value (approved by the majority of eligible voters in the county) or an equivalent amount raised by other means.

Because counties are constitutionally prohibited from raising more than 2 mills on the property valuation, a constitutional amendment was proposed to authorize an additional county ad valorem tax of 3 1/2 mills solely to finance the Indigent Health Care Act. The referendum failed and consequently the program is not funded at the time this report was being prepared. {See Recent and Proposed Changes}

#### Hospitals

For hospitals to receive reimbursement from the state and county, the act requires the hospital to perform certain duties. The hospital must determine whether the individual is eligible under the act, and must supply the county trust board with documentation of the recipient's eligibility and services provided.

The county trust board must review and certify the eligibility determination conducted by the hospital and transmit such

documentation to the state. The county shall make payment from the public trust fund for hospital services provided to an eligible recipient. Each county determines its own hospital payment formula.

### State

The state functions include reviewing the documentation of an individual's eligibility, and determining the type of hospital services to be reimbursed. The state shall also make an annual payment (in addition to the county payment) to the hospital based on the available monies. That is, each hospital's payment is a proportion of the total funds available, based on the hospital's share of total services provided to eligible indigents.

#### 1) Eligibility Standards

The Indigent Health Care Act defines an indigent as a person or head of household with:

- a) Income less than or equal to the federal poverty level (and has insufficient resources for self-care);
- b) lacks third-party coverage; and
- c) has made no transfer of assets for the purpose of establishing eligibility under this act at any time within the last 24 months; or
- d) an occurrence of a catastrophic illness resulting in an incurred medical debt-related to a hospital stay that exceeds fifty percent of the gross annual income of the person or household.

#### 2) Services and Providers

Only hospitals that are located in counties that have established a county indigent health care trust board and fund may participate. The hospital must conduct the eligibility determination and provide the documentation proving that the applicant meets the eligibility requirements. Only hospital services are reimbursed.

#### 3) Administration

##### a) Responsible Entities

The eligibility standards are specified under state

law. The participating hospital conducts the eligibility determination, which is reviewed by the county and the state. The county reimburses the hospitals with county funds and the state makes an annual payment to the hospital from state monies.

b) Funding Source

The state and county provide funds for hospital reimbursement.

c) Reimbursement Methodology

For county funds, each county determines its own payment mechanism. The annual state payment is based on the ratio of each hospital's annual indigent hospital care charges for eligible patients to the total amount of annual indigent hospital care charges for all participating hospitals. The state shall annually determine the amount available to the hospitals, and each hospital's share is determined by multiplying the hospital ratio with the total state monies available. The per diem payments to hospitals shall not exceed the individual hospitals Medicaid per diem rate.

4) Recipient and Expenditure Data

The law took effect in 1984, and no state or county monies have been expended under the program at the time this report was prepared.

5) Recent and Proposed Changes

In 1985, the legislature eliminated the requirement that counties participating in the Oklahoma Indigent Health Care Program must contribute to the Indigent Health Care Fund an amount equal to 3.5 mills on the dollar of assess valuation of all taxable property in the county. The act, HB 1222 of 1985, also establishes a check-off for donating part of an individual's tax refund to the Indigent Health Care Fund.





# OREGON

## I. STATE INDIGENT CARE PROGRAMS

### A. General Assistance-Medical

Oregon's General Assistance-Medical Program (GA-M) is a state-administered program.

#### 1) Eligibility Standards

##### a) Categorical

General Assistance recipients automatically qualify. Aged, blind, or disabled individuals may qualify if they are not eligible for Title XIX Medicaid, provided they meet all other Title XIX criteria other than income.

##### b) Income

No limits are placed on income, which is factored in the payment level.

##### c) Assets

Individuals and couples are eligible if they have less than \$50 in assets, excluding the home, an automobile, household effects, and \$1,500 for other fixed assets (\$2,250 for a couple).

#### 2) Services and Providers

##### a) Services Covered

The services covered and limitations on utilization are the same as the categorically needy component of the Title XIX Medicaid program, with the exception of inpatient hospitalization. Under Title XIX,

Oregon limits hospitalization to 18 days per year, while under the GA-M program, recipients are limited to 12 days per year.

### 3) Administration

#### a) Responsible Entities

The GA-M program is a state-administered program. The state establishes eligibility standards, conducts the eligibility determination and processes the providers' claims.

#### b) Funding Source

The GA-M program is 100% state funded.

#### c) Reimbursement Methodology

For inpatient hospital services, a flat fee is provided for outpatient services, payment is set at 75% of the public billing and practitioners are reimbursed at a percentage of usual and customary fees.

### 4) Recipient and Expenditure Data

#### a) Total Expenditures

##### General Assistance-Medical Expenditures

	FY 80	FY 81	FY 82	FY 83
IP/OP hospital	\$10.8	\$ 8.3	\$ 9.8	\$ 8.8
Physician	3.3	3.2	3.1	2.9
Dentist	0.2	0.3	0.1	0.1
Drugs	0.7	0.8	1.0	1.3
Other	0.5	0.5	0.5	0.5
Total	\$15.5	\$13.1	\$14.5	\$13.6

(in millions)

#### b) Recipients Served

Recipient counts not available.

# PENNSYLVANIA

## I. STATE INDIGENT CARE PROGRAMS

The commonwealth of Pennsylvania provides medical care under the state-administered General Assistance program. The program has two components: those who are categorically needy and the medically needy whose incomes are too high but who qualify under a spenddown provision that allows the subtraction of medical costs from the person's income.

The program also provides recipients of the State Blind Pension program with nursing home care, home and office visits of physicians or chiropractors, prescribed drugs, dental care, vision care, ambulance service, and visiting nursing service.

### A. General Assistance-Medical

#### 1) Eligibility Standards

##### a) Categorical

General Assistance recipients automatically receive medical care. These recipients are referred to as "categorically needy." A spenddown provision provides care to the medically needy.

##### b) Income

Individual ..... \$379-\$469  
Family of 4 ..... \$894-\$1,012

Limits varies by need and location of residence.

c) Assets

Individual ..... \$250  
Family of 4 ..... \$1,000

The home and auto are excluded.

d) Other

Numerous other groups of individuals may qualify for medical care under the General Assistance program: physically disabled adults not on SSI, mentally ill adults who are unemployable, persons 45 or older, persons employed 30 or more hours with incomes below GA benefit levels, and persons with lengthy work histories who have exhausted unemployment benefits.

## 2) Services and Providers

a) Services Covered

GA-Categorically Needy: The same services that are covered under the Title XIX Medicaid program are covered under the GA program.

GA-Medically Needy: The same services are covered that are covered by GA Categorically Needy, except that the medically needy do not receive prescription drugs or dental services.

b) Providers and Settings

The same settings and providers reimbursed under the Title XIX Medicaid program are covered under the GA program. Providers must sign agreements to receive reimbursement.

## 3) Administration

a) Responsible Entities

The state establishes the eligibility standards, conducts the eligibility determination and processes providers' claims.

b) Funding Source

The medical services provided under the General Assistance program are 100% state funded.



### c) Reimbursement Methodology

Inpatient hospital services are reimbursed on the basis of DRG; outpatient providers are reimbursed a percentage of their usual charge to the public. Other providers are reimbursed on an interim per diem basis, which is annually adjusted for costs.

### 4) Recipient and Expenditure Data

In fiscal year 1983-84, the state spent \$356.6 million to reimburse medical care provided to 239,496 recipients (duplicated count).

## II. LIMITED STATE INDIGENT CARE PROGRAMS

### A. Pharmaceutical Assistance for the Aged

The Pennsylvania legislature enacted a pharmaceutical assistance program for aged persons (H.B.6, Act 63, Laws 1983). The program began operations on July 1, 1984, and has enrolled 310,000 participants to date. To be eligible persons must be at least 65 years old, state residents, ineligible for public assistance, and have annual incomes less than \$9,000 for single persons or \$12,000 for married persons. (Income eligibility criteria will change to \$12,000 for single persons and \$15,000 for married persons effective April 1, 1985). The program covers all legend drugs, insulin and insulin supplies. Participants must make a copayment of \$4 for each prescription.

The program is funded from state lottery proceeds. The appropriation for FY 1985 was \$115,600,000, but program officials expect to spend only \$60-70 million during the first year.



# RHODE ISLAND

## I. STATE INDIGENT CARE PROGRAMS

### A. General Assistance-Medical

The General Assistance-Medical (GA-M) program is an optional program that all cities and towns participate in, which in effect renders the program a uniform, statewide program.

#### 1) Eligibility Standards

##### a) Categorical

General Assistance recipients and low-income families with dependent children who are not eligible for Title XIX Medicaid are automatically eligible for GA-M.

##### b) Income

Varies by computation of payment.

##### c) Assets

Applicants may have no liquid assets. For recipients:

Individual .....	\$1,000
Family of 4 .....	\$1,000

The home, household furnishing, and an automobile up to \$1,500 of equity value are excluded.

## 2) Services and Providers

Under GA-M, the services covered, the type of providers reimbursed, and their limitations are the same as the state's categorically needy component of the Title XIX Medicaid program.

## 3) Administration

### a) Responsible Entities

The General Assistance-Medical program is jointly administered by the state and the city. Although a country may administer its own GA-M program, it will receive no state funds under such circumstances. Currently, with all the cities and towns participating, the state establishes the eligibility criteria, while the city conducts the eligibility determination and processes providers' claims.

### b) Funding Source

The GA-Medical program is 100% state funded.

### c) Reimbursement Methodology

For inpatient and outpatient hospital services, payment is on a prospective basis determined by cost-based reasonable charges. Other providers are reimbursed according to a negotiated fee schedule. Both payment mechanisms are the same as the state's Title XIX Medicaid program.

## 4) Recipient and Expenditure Data

### a) Total Expenditures

	FY 80	FY 81	FY 82	FY 83
GA-M	\$ 6.7	\$ 8.1	\$ 9.4	\$10.2

(in millions)



b) Recipients Served

## General Assistance-Medical\*

	FY 80	FY 81	FY 82	FY 83
GA-M	4,021	4,511	4,455	4,978

\* Unduplicated, annual figure.

## IV. HEALTH INSURANCE ALTERNATIVES

Catastrophic Health Insurance Program

In 1975, Rhode Island implemented a catastrophic health insurance program, established minimum health insurance standards, and required employers to make an HMO option available to employees. In addition, the state created a risk-sharing pool to provide health insurance to people unable to obtain it due to a pre-existing medical condition.

Rhode Island's catastrophic health insurance program (CHIP) is structured so that the state pays the medical expenses of persons who suffer catastrophic medical expenses after they have exhausted their health insurance benefits and have paid the mandatory deductibles (called personal resource payments). There is no maximum placed on CHIP program benefits.

Deductibles are structured to provide incentives for individuals to carry health insurance coverage. That is, people with comprehensive or "qualified" health insurance plans have lower mandatory deductibles than people with less comprehensive coverage (referred to as semi-qualified or nonqualified plans). The following table illustrates program deductibles.

Health Insurance	Fixed Amount	% of Allowable Income
Qualified Plan	\$ 1,035	10% or 12.5%
Semi-qualified plan	\$ 2,588	25%
Non-qualified plan	see definition below	see definition below
Qualified Medicare plan	\$ 1,035	5%
Non-qualified Medicare plan	\$ 2,070	10%
No health insurance plan	\$10,350	50%

Source: Rhode Island Comprehensive Health Insurance Plan Eligibility Brochure. These figures reflect the doubling of deductibles in 1983 and their indexing to the Social Security Cost of Living Adjustment (COLA) in 1984. Indexing of deductibles is now a permanent part of the program.

#### Qualified Health Plans

Qualified health plans include those that cover the following services:

- semi-private hospital coverage for at least 120 days;
- a medical and surgical plan providing coverage for usual and customary physician charges; and
- major medical coverage providing at least \$10,000 in supplemental coverage.

Those with income up to \$39,399 must pay 10% of their allowable income, which is defined as the family adjusted gross income less a \$1,000 exemption for each family member. Families with incomes in excess of \$40,000 must pay a deductible equal to 12.5% of allowable income.

#### Semi-Qualified Health Plans

Semi-qualified plans are those with all the provisions of a qualified plan except major medical coverage.

#### Non-Qualified Health Plans

Non-qualified plans do not conform to either qualified or semi-qualified plan requirements. Those enrolled in non-qualified plans can receive CHIP benefits, but their deductible will be increased by the difference -- not to exceed \$2,070 -- between what their plan pays and what a

qualified plan would pay.

#### Qualified Medicare Health Plans

Qualified Medicare plans are those which include Medicare Parts A and B plus a qualified supplemental health insurance plan.

#### Non-Qualified Medicare Health Plans

Non-qualified Medicare plans are those that provide Medicare Parts A and B coverage but no supplemental coverage

#### Covered Services

Covered Services include:

- hospital services, excluding private rooms;
- physicians' services;
- skilled nursing facility and visiting nurse services covered by Medicare;
- prescription drugs;
- durable medical/surgical equipment rental, lease, or purchase, whichever is least;
- ambulance services;
- dental services, limited to surgery of the jaw or related structures or to dental services required as the result of an accident;
- chiropractic services, limited to the manual manipulation of the spine to correct a subluxation identified by x-rays;
- speech and physical therapy;
- radiological services; and
- diagnostic services.

Services explicitly excluded from coverage include:

- benefits provided pursuant to federal or state law;
- custodial or domiciliary care;
- most cosmetic surgery;
- psychological therapy and social counseling, unless medically necessary;
- outpatient psychiatric care in excess of 50% of the cost of eligible care in a calendar year;
- services delivered in facilities not certified by the health director to provide such services;
- health services delivered in state-operated facilities; and
- experimental health services.



### Experience

Analysis of program expenditures reveals that most persons served by CHIP are low income, with the average recipient's family income reported at \$6,877 for FY 1984. The bulk of recipients are either middle aged or elderly. Fifty-four percent were covered by Medicare in the years 1975-79, even though Medicare recipients constitute only 13% of the state's population.

Analysis of program expenditures conducted by the National Center for Health Services Research during the same time period reveals that five services -- hospital inpatient (medical), hospital inpatient (psychiatric), nursing homes, prescription drugs, and hemodialysis -- accounted for 94% of program expenditures. Of continuing concern to program officials is the fact that inpatient psychiatric costs account for a disproportionate (and increasing) percentage of program expenditures. In the first half of 1980, over half of program expenditures were for psychiatric services, even though people receiving these services accounted for only 18% of program recipients. This disproportionate distribution of expenditures results from the structure of psychiatric benefits. The program pays 100% of inpatient psychiatric costs, but requires a copayment for 50% on outpatient benefits.

In addition, a large portion of psychiatric care is rendered in out-of-state facilities, which are more expensive than in-state facilities. Despite the financial strain that psychiatric costs have imposed on the program, no consensus seems to be emerging to curtail psychiatric benefits.

After an initial start-up period, Rhode Island's catastrophic health program experienced a steady but fairly moderate rate of growth. However, in FY 1983, the legislature made several changes that reversed the program's rate of growth. It doubled program deductibles and raised deductible for people entering their second or subsequent year of application from 35% to 50% of the first year's deductible. Deductibles for FY 1984 were indexed to Social Security's cost of living adjustment (COLA), resulting in a further increase in deductibles.

The legislature also reduced the FY 1984 appropriation to \$1 million, a reduction of \$1.5 million from FY 1983's appropriation. However, the reduced appropriation had far less impact than one might have anticipated. The program was legally required to continue providing services to all eligible persons; the \$1.3 million deficit that occurred eventually was reversed by a supplemental appropriation from general revenue funds. The following table shows program expenditures and the number of people served.



## CHIP

	FY 78	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
Recipients	\$1.70	\$2.33	\$2.45	\$2.15	\$2.53	\$2.85	\$2.33	\$2.27
Expenditures	921	1,122	1,239	1,161	901	898	701	621

\* Expenditures in millions

Sources: National Center for Health Services Research, State Options for Addressing Catastrophic Health Expenses, Volume Two, p.32; and Rhode Island Dept. of Health CHIP Program.

This table indicates that 1983 program changes resulted in decreases in both expenditures and numbers of people served. The number of eligible families dropped 32% from FY 84, while the number of new applications dropped 52% during the same period. Changes in program deductibles, coupled with the indexing of deductibles to COLA, will probably continue to result in decreased expenditures and lower numbers of recipients.



# **SOUTH CAROLINA**

## **I. STATE INDIGENT CARE PROGRAMS**

### **A. Medically Indigent Assistance Fund**

Effective January 1, 1986 , the South Carolina Health and Human Services Commission shall implement SB 2118 that establishes the Medically Indigent Assistance Fund. The Fund is financed by an assessment on general hospitals and assessment on counties. Both assessments must contribute the same amount of monies and for the first year of implementation, the total contribution to the Fund shall equal \$15 million. There is no state or federal contribution to the Fund.

The annual assessment on each general hospital is based on the hospital's ratio of net to gross patient revenue, multiplied by the total number of patient days. Net patient revenue excludes contractual allowances, bad debts, uncompensated indigent care, property taxes, and state and federal income taxes. The county assessment is based on a formula that equally weighs the county property value, per capita income, and net taxable sales. Based on the recommendations of the Health and Human Services Finance Commission, the General Assembly shall determine in the annual appropriations act, the total amount of monies to be raised by the assessments. Each assessment shall be adjusted to raise the amount designated by the General Assembly. If the county has established an eleemosynary institution (a public charity hospital) to provide medical care to the indigent, the contributions to the Medically Indigent Assistance Fund by such a hospital must be credited against the county assessment.

Monies deposited into the Fund must be used solely to compensate general hospitals for providing medical care to medically indigent persons. In the event of a shortage of funds in any given year no additional assessments are to be made against the county or general hospitals, and the state is not responsible for providing any supplemental funding.

The Health and Human services Finance Commission is responsible for implementing and administering the Medically Indigent Assistance Fund. The Commission must issue emergency regulations implementing the Fund by January 1, 1986. The regulations must designate the method of administration,

including the specific procedures and materials to be used statewide in determining eligibility in both emergency and nonemergency situations; the population to be served; the health care services covered; a prospective payment system based on costs rather charges; and a method for processing and paying claims.

The legislation defines the term medically indigent as persons whose gross family income falls at or below the federal poverty guideline, have been domiciled in South Carolina for at least 6 months, and who meet certain qualifying criteria regarding real property. All persons whose gross family income falls between one hundred percent and two hundred of the federal poverty guidelines are eligible for partial payment from the Fund based on a sliding fee scale. The Fund is the payer of the last resort which means payment from the fund shall not occur until all other means of paying for or providing services have been exhausted.

The law also requires the Commission to develop a uniform data base on hospital treatment of the medically indigent. The legislation prohibits the hospitals from denying treatment to persons based on their lack of ability to pay when a member of the admitting hospital's medical staff determines the person is in need of care.

## II. LIMITED STATE INDIGENT CARE PROGRAMS

### A. Midlands Hospitals Indigent Care Partnership

A partnership has been formed (in 1984) by the four general acute care hospitals in the Greater Columbia, South Carolina area in response to insufficient funds from Medicaid and other government programs to cover the full needs of medically indigent persons. The Midlands Hospitals Indigent Care Partnership consists of Richland Memorial Hospital, Providence Hospital, Baptist Medical Center (all located in Richland County) and Lexington County Hospital. The Partnership coordinates with one fund and creates another from which the participating hospitals may draw from (to varying degrees) to cover indigent care expenses.

The Richland County Medically Indigent Fund is administered and financed by the Richland County Council. Lexington County Hospital is not eligible to receive monies from this fund. All payments are made at a rate of 80% of charges and cover inpatient services delivered by the three hospitals. It is estimated by the hospitals, however, that the Richland County



Fund would only cover 50% of the inpatient costs for care provided to the medically indigent.

Therefore, the Partnership has created the Midlands Hospitals Indigent Care Partnership Fund that is financed by the four participating hospitals. The four hospitals agree on a total amount to be deposited in the fund (based, in part, on the limited appropriations to the Richland County Fund). Each hospital's contribution is derived by: multiplying a hospital's ratio of its inpatient costs to total inpatient costs of the four hospitals, with the total amount to be deposited into the Partnership Fund.

Prior to receiving monies from the Partnership Fund, each hospital must provide a certain level of charity care (this level being referred to as the "threshold") to Lexington-Richland County residents. The total amount of the thresholds is equal to the shortfall in funding. For example, the hospitals might estimate that the hospital charity care need (in addition to Hill-Burton requirements) will be \$10 million, but the two funds provide only \$8 million. The shortfall of \$2 million is to be distributed to the hospitals by the same inpatient hospital cost ratio used in determining the hospital's contribution to the Partnership Fund. No hospital may receive Partnership Funds until they have met their charity care threshold. Any hospital not meeting its threshold amount is required to deposit the difference into the Partnership Fund. Richland Memorial Hospital cannot draw from the Partnership Fund until the Richland County Council Fund is depleted and it has met its threshold amount.

The Partnership Fund is administered by an operating committee consisting of a representative from each hospital. The Partnership has agreed to eligibility standards and each hospital is responsible for determining the eligibility of each applicant.

At the onset, the Partnership Members were quite explicit in stating that the arrangement was a short-term solution to enable acute-care hospitals in Lexington and Richland County to remain financially viable so that longer term solutions could be found. Since the formation of the Partnership, South Carolina has created a Medically Needy program under Medicaid, and the Medically Indigent Assistance Fund that reimburses acute-care hospitals for rendering care to indigent patients.

#### B. Sickle Cell Anemia

South Carolina funds a program for adults who have been diagnosed as suffering from sickle cell anemia. (The state also operates a program for children with sickle cell anemia that is funded by both federal and state funds.) Persons who have

sickle cell anemia are eligible to participate if their household income does not exceed 200% of the federal poverty level. The program reimburses providers for clinic services and occasionally for hospital services. The state appropriated \$80,000 to the program in FY 1983 and 1984; the appropriation for FY 1985 has been increased to \$180,000. As of June 1984, 186 adults were participating in the program.

#### V. CERTIFICATE OF NEED PROVISIONS AFFECTING INDIGENT CARE

A regulation requires certificate-of-need applicants to include a description of plans to provide indigent persons with access to care. Applicants are also required to report their expenditures for indigent care during the 3-years preceding their application and to state what percentage of their gross revenues they will commit to providing indigent care. Applicants must also design their admissions policies to ensure access to care for indigents. The Board of Health may deny applications that do not contain sufficient provisions allowing indigents sufficient access to medical care.

# SOUTH DAKOTA

## I. STATE INDIGENT CARE PROGRAMS

### A. Catastrophic County Poor Relief Fund

In 1984, the South Dakota legislature enacted Senate Bill 125, which established the Catastrophic County Poor Relief Fund. The law became effective January 1, 1985, and will permit any participating county to draw from the fund when an individual eligible for county poor relief incurs hospital or medical expenses in excess of \$20,000. Certified county claims -- reviewed and approved by the state Catastrophic County Poor Relief Board -- will be reimbursed for 90% of the costs in excess of \$20,000.

The Catastrophic County Poor Relief Fund received a one-time "startup" appropriation of \$500,000 from the state. Subsequent funding, solely by counties, is limited to replacing that portion of the initial reserve expended during the previous year. If the fund is in danger of being depleted, the board may impose an additional county assessment.

Each county is assessed in the following manner:

1. The county's percent of total population of the counties participating (excluding Medicaid eligibles from the county and state totals ) is determined;
2. The county's percent of total full and true property valuation of the participating counties is determined; and
3. The average of 1 and 2 is multiplied by the total assessment needed to replenish the Catastrophic County Poor Relief Fund.

The program is jointly administered by the state and the Catastrophic County Poor Relief Board, with the latter responsible for policy and program decisions. The board is a



5-member panel consisting of county commissioners appointed by the executive board of the association of county commissioners.

A key provision of the law required that at least 50 (out of 66) counties request participation in the fund before November 1, 1984, for the law to go into effect. That requirement was met. If at the end of any calendar year fewer than 35 counties elect to remain in the fund, a final assessment will be made to restore the reserve. The fund will then be discontinued, and the reserve will revert to the state general fund.

## II. LIMITED STATE INDIGENT CARE PROGRAMS

### A. Kidney Disease Program

South Dakota operates a program that provides assistance for persons suffering from chronic kidney disease and requiring dialysis or a transplant. Recipients must be eligible for Medicare's End-Stage Renal Dialysis program, must meet income eligibility criteria, and must make a copayment. Income eligibility criteria are structured in the form of "income disregards," which means that household incomes below that level are disregarded in computing program deductibles. One person may disregard \$10,000, two-person families may disregard \$12,000, three-person families may disregard \$13,000, four-person families may disregard \$15,000, and five-person families may disregard \$15,000 plus \$1,000 for each family member over 4. Recipients must make a copayment equal to 20% of their income above that income disregard. The maximum that may be expended on behalf of any individual is \$5,000; the program does not pay for transplants.

The program was appropriated \$374,000 for FY 1985 and expects to serve 119 people.



# TENNESSE

## I. STATE INDIGENT CARE PROGRAMS

Tennessee does not have a state or state-county indigent care program. County general assistance programs may reimburse providers for medical care, but the benefits and eligibility criteria vary by county.

## II. LIMITED STATE INDIGENT CARE PROGRAMS

### A. Speech and Hearing Program

Tennessee's Speech and Hearing program is a state-funded and -administered program that provides hearing tests and aids to children under the age of 21. In 1983, 4,252 recipients received aid from physicians, speech hearing centers, speech pathologists, and audiologists.

### B. Hemophilia Program

Tennessee has a state-administered program that provides blood supplies and treatment to hemophiliacs unable to afford necessary care. Services include hospitalization; however, the majority of program costs are for blood and blood products. Limitations on services include \$10,000 per year for antihemophiliac factor, 7 days per year for inpatient hospitalization (to treat a bleeding episode), and dental services (considered on an individual basis).

## Hemophilic Data

	FY 81	FY 82	FY 83	FY 84
Recipients	N/A	277	296	317
Expenditures	\$520,000	\$463,000	\$552,000	\$447,000

C. Chronic Renal Disease

Tennessee has a state-administered program to assist persons suffering from chronic renal diseases who are unable to pay for lifesaving care or treatment. Reimbursement is provided to hospitals (inpatient and outpatient care), dialysis clinics, physicians, laboratories, and pharmacies.

Eligibility is limited to individuals with annual incomes of less than \$6,500. For a family of four, the annual income is limited to \$10,600. The home, income-producing property, and one auto are excluded from the determination of assets.

## Chronic Renal Disease Data

	FY 81	FY 82	FY 83	FY 84
Recipients	659	743	943	1,052
Expenditures	\$765,000	\$1,156,000	\$1,073,000	\$704,000

# TEXAS

## I. STATE INDIGENT CARE PROGRAMS

In the 1985 regular and special legislative sessions, Texas adopted a series of laws clarifying governmental responsibility for treating medically indigent persons. The major bills adopted include: The Indigent Health Care and Treatment Act; the Primary Health Care Services Act; the Maternal and Infant Health Improvement Act; and HB 1963 which amends the hospital licensure law.

### Indigent Health Care Treatment Act

Senate bill 1-X, adopted during a special session of the Texas legislature, established the Indigent Health Care and Treatment Act. The purpose of the act is to clarify county responsibility for providing medical care to indigent residents. The law sets different requirements for counties, depending on whether the county supports a public hospital, is located within a hospital district, or if the county has neither a public hospital nor a hospital district.

Title I of the Act contains general provisions which include: Defining an indigent's county of residence; permitting a county to impose nominal copays; and requiring the state to establish statewide eligibility standards and procedures for determining eligibility. In developing the eligibility standards, the state is to utilize existing AFDC-Medicaid standards to the extent possible. A county is permitted to adopt less restrictive standards, however.

Title II establishes, for the first time, county responsibility for indigents residing in counties that are not served by a public hospital or a hospital district (these entities are already required to provide medical treatment to resident indigents). Counties must review a recipient's eligibility at least once every six months.

Each county, under Title II, must provide the same services that are mandated under the categorically needy component of the Medicaid program with the exceptions of EPSDT services, which are not required, and prescription drugs, which are



required. Counties may cover additional services. A county's payment liability for each recipient is 30 days of hospitalization or treatment in a skilled nursing facility (or a 30-day combination of both), or a maximum total payment of \$30,000 per recipient, whichever occurs first during the fiscal year. Payment for services is to be based on Medicaid payment principles.

State financial assistance--through the Indigent Health Care Assistance Fund--is available for counties that expend at least 10 percent of their general revenue levy to provide mandatory medical services to eligible recipients. The state assistance shall be limited to 80 percent of the payment for medical services provided after the 10 percent requirement is met. The legislature appropriated, for county assistance, \$0.5 million for fiscal year 1986, and \$2.5 million for fiscal year 1987. Counties that reimburse additional services not mandated by law, cannot use payment of such services as credit towards the 10 percent requirement. If the state does not appropriate monies to the Fund, counties are not required to provide services beyond 10 percent of their general revenue levy.

Title III pertains to those counties served by a public hospital or a hospital district. Each county owning, operating, or leasing a public hospital is required to provide sufficient funding to the hospital to provide health care assistance to the indigent. A county with a public hospital has the same payment standards (those established under Medicaid) and total payment maximums (30 days or \$30,000) as counties without public hospitals. Public hospitals are only required to provide inpatient and outpatient services. Hospital districts must provide services as required by the statute creating the district authority.

Counties are not required to provide health care assistance until September 1, 1986. The act also delineates requirements for the provision of emergency services by providers not part of the county indigent delivery system. Title IV of the act would have enumerated responsibilities for indigent health care districts. Title IV will not go into effect, however, because SJR 29--which would have proposed a constitutional amendment permitting the creation of such districts funded by their own taxing authority--was not adopted by the Texas legislature.

#### Primary Health Care Services Act

The Primary Health Care Services Act of 1985 authorizes the state to create a primary health care services program for the indigent. The Texas Board of Health has broad authority to establish the structure of the program, the type and amount of services covered, the selection of providers, and the eligibility criteria. The program is to be coordinated with other assistance programs.



Given that the legislation is not very specific about program structure or eligibility, the Department of Health is to develop a long-range plan that is to be submitted to the governor and legislature by January 1, 1986. Some of the points to be addressed by the long-range plan are: output and outcome indicators; indentification of priority client population; minimum types of services to be covered; and coordination of administration and service delivery with other assistance programs. A two-year short-range plan is to be developed from the long-range plan.

Services under this plan are not to be provided until January 1, 1986. The legislature appropriated \$2.5 million for the fiscal year 1986 and \$5.5 million for fiscal year 1987 for sevicees provided under the Primary Health Care Services Act.

#### Maternal and Infant Health Improvement Services Program

The third piece of legislation that provides medical services to certain medically indigent persons is the Maternal and Infant Health Improvement Act of 1985 (formerly HB 1023). The act authorizes the Texas Board of Health to establish a program to deliver comprehensive maternal and infant health services and auxillary services to eligible women and infants. An infant is defined as a child under the age of 12 months. Reimbursable services includes preventive, health, medical, assessment, nursing, and other services necessary to avert or limit the occurrence of maternal, fetal, and infant deaths, low birth-weight infants, handicapping conditions, unplanned adolescent pregnancies, and births without appropriate intrapartum care.

A goal of the legislation is to complement or supplement existing state, federal and local programs that assist infants and pregnant women. The legislation specifically assigns program priority to low-income women and infants who are not eligible for similar services through any other public program.

The Texas Board of Health is to develop the rules relating to service coverage and general administration of the program. The board is also responsible for issuing rules, based on a statewide determination of need, that establishes a system of funding priorities in the event of budget limitations.

An individual cannot directly access the program; rather, an applicant must be referred to the program by a physician, nurse midwife, medical social worker, community health center, health facility, or any other source acceptable to the board. To be eligible, the applicant must be a resident of the state and certified by a physician as meeting the medical criteria established in the program rules. Furthermore, the physician must have reason to expect that delivery of the services will prevent or reduce the probability of maternal, fetal or infant death, complications of pregnancy, or adolescent pregnancy.

The Texas Department of Health determines an applicant's eligibility and is permitted to charge fees for the services delivered. If the Board of Health determines that the existing private or public providers are unavailable or unable to provide the program services, the Department of Health may directly deliver the services.

The department is responsible for issuing several reports on the program. A six-year long-range plan must be submitted to the governor and legislature by January 1, 1986. The long-range plan, to be updated every two years, must include sufficient data to measure the effectiveness of the program. A two-year short-range plan is to be based on the six-year plan and every two years, as part of their budget preparation process, the Department of Health must assess the progress made toward achieving the goals identified in each plan (long- and short-range).

The board may appoint a statewide advisory committee to the Maternal and Infant Health Improvement Services program, and any necessary areawide advisory committees.

#### Hospital Licensure and Patient Transfers

The hospital licensing law was amended by HB 1963 to include minimum standards governing the transfer of patients for nonmedical reasons. The transferring hospital must: notify the receiving hospital to ensure the patient meets the receiving hospital's admission criteria; use appropriate life support measures to stabilize the patient during the transfer; accompany the patient en route to the receiving hospital; and transfer all necessary medical records. The state hospital licensing agency may deny, suspend, or revoke a hospital's license for substantial noncompliance.

# UTAH

## I. STATE INDIGENT CARE PROGRAMS

### A. Indigent Medical Assistance Program

Under state law, local county governments are responsible for providing medical care required by low-income persons who are not covered by other state or federal programs and unable to pay. The state has an optional indigent care program, called the Indigent Medical Assistance Program (IMAP), available to counties.

IMAP is state administered but financed by both the state and participating counties. To participate, a county must contribute a 1/4-mill levy of the county's total assessed property value to IMAP. In turn, the state sets uniform eligibility criteria, certifies eligibility, and reimburses providers. The state finances all costs over the county assessment. In 1984, 16 out of 29 counties participated in IMAP (representing 75 percent of the state's population), although some of the nonparticipating counties administer their own indigent care programs.

#### 1) Eligibility Standards

##### a) Categorical

The program has no automatic eligibility provision for county general assistance recipients.

##### b) Income

Individual .....	\$286/month
Family of 3 .....	\$384/month
Family of 4 .....	\$607/month



c) Assets

Individual ..... \$500/month  
Family of 2 or more ... \$750/month

d) Other

Transients are covered once.

## 2) Services and Providers

a) Services Covered

IMAP covers those services necessary to diagnose and treat emergency medical care and life-threatening illness. All services require prior authorization except for emergencies. Covered services include:

- Inpatient hospital care
- Physicians' services
- Limited outpatient hospital care
- Prescription drugs
- Emergency transportation.

b) Providers and Settings

Providers may be reimbursed under IMAP if the services are covered and the recipient's condition was life threatening, or if services were prior authorized.

## 3) Administration

a) Responsible Entities

The Utah Department of Health establishes the eligibility standards, conducts the eligibility determination, and processes providers' claims.

b) Funding Source

A participating county must annually contribute a 1/4-mill levy on assessed property values. The state covers the rest of the expenses.



The percentage of funding by the state varies by year:

State Share of IMAP funding

FY 80 .....	69%
FY 81 .....	60%
FY 82 .....	61%
FY 83 .....	62%

c) Reimbursement Methodology

Reimbursement for inpatient care is on the basis of DRGs, with all other services on a prospective basis.

4) Recipient and Expenditure Data

a) Total Expenditures

Indigent Medical Assistance Program

Services	FY 80	FY 81	FY 82	FY 83
IP hospital	N/A	N/A	\$1.5	\$1.9
OP hospital			0.4	0.5
Physician			0.1	0.1
Clinics			0.1	0.1
Drugs			0.1	0.1
Other			0.1	0.2
Total	\$2.3	\$2.0	\$2.3	\$2.9

(in millions)

b) Recipients Served

## Indigent Medical Assistant Program\*

	FY 80	FY 81	FY 82	FY 83
IMAP*	2,048	2,603	2,605	3,229

\* Unduplicated annual counts

During 1979, the Utah Department of Health conducted a survey of 92 randomly selected IMAP recipients. The survey found the recipients were evenly distributed between males and females and had an average age of 42. Forty-two percent were in single-member households; 84% were unemployed. Forty-eight percent sought care because of chronic illness, 23% for accidents, 21% for acute illness, and 8% for infections.

# VERMONT

## I. STATE INDIGENT CARE PROGRAMS

### A. General Assistance - Medical

Vermont has a limited program providing physician and other types of services to individuals receiving state General Assistance payments. The services provided are for emergency treatment and do not include inpatient hospital services.

#### 1) Eligibility Standards

##### a) Categorical

The medical program is part of the state General Assistance program, and General Assistance cash recipients are automatically eligible.

##### b) Income

Individual .....	\$305/month
Family of 4 .....	\$539/month
Exclusions .....	none

#### 2) Services and Providers

##### a) Services Covered

<u>Services</u>	<u>Limitations</u>
Physician services	For emergency treatment or for examinations to establish capability of employment.
Dental services	Emergency care to relieve pain.
Vision care	Emergency eye care when delay

in treatment would be contrary to the well-being of the individual.

Pharmacy

Prescribed drugs, certain medical supplies, and certain durable medical equipment.

Ambulance

Must be certified by a physician as necessary.

b) Providers and Settings

Provider coverage is limited to physicians, pharmacists, dentists, and Medicare-certified ambulance companies.

3) Administration

a) Responsible Entities

The state establishes the eligibility standards, conducts the eligibility determination, and processes providers' claims.

b) Funding Source

The General Assistance program is 100% funded by the state.

c) Reimbursement Methodology

For most services, the fee schedule of the Title XIX Medicaid program is used.

4) Recipient and Expenditure Data

Not available.



# VIRGINIA

## I. STATE INDIGENT CARE PROGRAMS

The Commonwealth of Virginia has four major programs that provide some type of medical care to the indigent. For the sake of clarity, the two ambulatory components of the General Assistance program -- Ongoing and Emergency -- are described separately. In 1984, 59 General Relief Plans out of 127 included ongoing medical assistance, and 74 included emergency medical assistance. Thirty-nine plans included both emergency and outgoing care.

### A. State and Local Hospitalization Program

The State and Local Hospitalization (SLH) program is an optional program in which 100 cities or counties provided inpatient hospital care during fiscal year 1983-84. The participating cities and counties represent 90% of the state's total population. Forty-four cities or counties covered outpatient hospital care.

#### 1) Eligibility Standards

##### a) Categorical

None

##### b) Income

The state suggests guidelines, but the city/county has the option of establishing more stringent or more liberal standards for eligibility.

### Suggested State Guidelines

Individual .....	\$285/month
Family of 2 .....	\$375/month
Family of 4 .....	\$555/month

#### c) Assets

The only asset allowed is the house occupied by the patient.

#### 2) Services and Providers

The following are the only services and providers covered by the SLH program:

<u>Service</u>	<u>Limitations</u>
IP hospital	\$30.00 deductible for each nonemergency admission except pregnancy-related visits or for patients under the age of 21.
OP hospital	\$2.00 for each nonemergency visit.
OP health department clinic	\$1.00 for each nonemergency visit except for family planning.

#### 3) Administration

##### a) Responsible Entities

Although the state suggests eligibility guidelines, the county sets the eligibility standards, conducts the eligibility determinations and processes providers' claims.

##### b) Funding Source

Overall, 75% of SLH funds are provided by the state. The state match is made available on the basis of population. A portion of the state share, and the portion of the state share not claimed by a locality are retained in a reserve fund. Localities that spend more than their allocation can draw from the reserve fund.

c) Reimbursement Methodology

Reimbursement for inpatient care is cost based, while payment for an outpatient hospital visit is a fixed, all-inclusive rate. The contracts for medical services are subject to approval by the State Board of Social Sciences. The board has established a policy that no contract rate will exceed 115% of the average cost of all hospitals within the region. A locality pays the hospital or clinic directly for services rendered and is reimbursed by the state at a rate of 75% of the bill until the locality's allocation (based on population) is depleted.

## 4) Recipient and Expenditure Data

a) Total Expenditures

## State-Local Hospitalization Program Expenditures

	FY 80	FY 81	FY 82	FY 83
SLH	\$ 5.7	\$ 6.3	\$ 7.2	\$ 8.2

(in millions)

b) Recipients Served

## State-Local Hospitalization Recipients\*

	FY 81	FY 82	FY 83
SLH	4,868	5,242	5,704

\* Monthly average, duplicated count.

## 5) Recent and Proposed Changes

In 1980, the legislature increased the state match from 50% to 75%.

## B. General Relief-Ongoing Medical Assistance

This program covers ambulatory services (i.e., nonhospital) and has a limit of \$500 of medical expenditures per recipient per month.

### 1) Eligibility Standards

#### a) Categorical

Recipients of Ongoing General Relief assistance are eligible for ongoing medical assistance if the component is included in the locality's plan.

#### b) Income

The state defines the standard of need.

#### c) Assets

Assets must be \$600 or less, with one auto, the house, and certain income-producing property exempt.

#### d) Other

The individual must comply with requirements of the Employment Services program.

### 2) Services and Providers

#### a) Services Covered

A local General Relief-Ongoing Medical Assistance program may cover the following services:

- Services of a licensed physician;
- Other practitioners upon referral by a physician;
- Supplementary services (laboratory tests and x-rays);
- Drugs, medical supplies, and appliances essential to health and personal functioning;
- Dental care;
- Medical transportation.

Localities specify the services provided and what type of limitations (such as prior authorization) to



impose. Services provided vary by locality. For example, as of May 1, 1984, 59 localities provided prescriptions from ongoing medical assistance, but only eight provided dental care.

b) Providers and Settings

Designation of which providers are eligible depends on the local agency plan; however, hospitals are not eligible and physicians are not eligible for reimbursement of inpatient hospital care.

3) Administration

a) Responsible Entities

The GR-Ongoing Medical Assistance program is a state-local program. The state and locality jointly establish the eligibility standards, while the locality conducts the eligibility determinations and processes providers' claims.

b) Funding Source

The state provides 62.5% of the funding for Ongoing Medical Assistance up to the \$500 monthly limit. Any expenditure over that amount must come from local funds.

c) Reimbursement Methodology

The localities may specify the amount reimbursed. Payments are not made solely to providers; a recipient can receive money by a grant and be responsible for paying for regular medical needs.

4) Recipient and Expenditure Data

a) Total Expenditures

General Relief-Ongoing Medical Assistance  
Expenditures\*

	FY 81	FY 82	FY 83
GR-Ongoing	\$466,678	\$428,117	\$560,912

\* These figures include expenditures matched by the state. Localities may spend over the \$500 limit, but that amount is not included in these figures.

b) Recipients ServedGeneral Relief-Ongoing Medical Assistance  
Recipients\*

	FY 81	FY 82	FY 83
Ongoing	9,438	8,632	9,076

\* Duplicated, annual count

## 5) Recent and Proposed Changes

Some localities have dropped the Medical Assistance component of their General Relief programs.

C. General Relief-Emergency Medical Assistance

## 1) Eligibility Standards

a) Categorical

None

b) Income

Determined by the localities.

c) Assets

Determined by the localities.

## 2) Services and Providers

a) Services Covered

The locality selects the services covered. The services a locality may chose to cover include those covered under the General Relief-Ongoing Medical Assistance program plus nursing home care.

b) Providers and Settings

Eligible providers depend on the local agency's plan however, hospitals are not eligible, and physicians are not eligible for reimbursement for inpatient care.

## 3) Administration

a) Responsible Entities

The optional General Relief-Emergency Medical Assistance program is administered by the county. Thus, the locality establishes eligibility standards, conducts eligibility determinations and processes provider's claims. The state's role is limited to assistance in the program's financing.

b) Funding Source

The state provides 62.5% of the funding for the Emergency Medical Assistance program, up to the \$500 limit. Any expenditure over that amount must come from local funds.

## 4) Recipient and Expenditure Data

a) Total Expenditures

## GR-Emergency Medical Assistance Expenditures\*

	FY 81	FY 82	FY 83
Emergency	\$108,404	\$145,066	\$128,826

\* Does not include local expenditures not matched by state funds.

b) Recipients Served

## GR-Emergency Medical Assistance Recipients\*

	FY 81	FY 82	FY 83
Emergency	3590	3077	4164

\* Duplicated, annual count

### 5) Recent and Proposed Changes

Some localities have dropped the Medical Assistance components of their General Relief programs.

## D. State Teaching Hospitals

### Medical College of Virginia and University of Virginia

The Medical College of Virginia (MCV) in Richmond and the University of Virginia (UV) in Charlottesville provide medical care to indigents who do not qualify for categorical medical care programs or whose benefits have been exhausted. Services are limited to inpatient and outpatient hospital services available at the MCV and UV teaching hospitals.

Eligibility standards, established by the state under the appropriation act for both hospitals, are based on federal poverty guidelines. An ability-to-pay schedule has been developed and is updated annually to reflect inflation. If an indigent is at or below the guidelines, medical care is provided free of charge. If an individual is above the eligibility guidelines, the patient may be determined medically indigent and be responsible for a copayment of 10%, 25%, 50%, or 75% of the billed amount, depending on the family unit and amount of income.

The hospital, which is responsible for conducting the eligibility determination, is required to identify any third-party coverage for another payment program. If the individual does not qualify for such benefits, lacks the resources to pay, and meets the eligibility criteria, then the patient is referred to the indigent care program. In fiscal year 1983, the indigent care appropriation at UV had an average value of \$2,019. The average value for the outpatient account was \$86 at UV and \$70 at MCV (the number of outpatient accounts is not available).

In the 1982-84 biennial budget, the teaching hospitals received \$94.3 million for indigent care. The appropriation for the 1984-86 biennium is \$134.1 million. This jump (42%) in expenditures is one reason the legislature created a study commission to examine Virginia's indigent care policy. Specifically, UV Hospital was appropriated \$25.4 in FY 1985 and \$28.9 in FY 1986 MCV was appropriated \$37.9 in FY 1985 and \$41.9 in FY 1986.



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Eastern Virginia Medical Authority

The Eastern Virginia Medical Authority (EVMA) has received state funds for indigent care since 1978. Roughly half of the EVMA indigent care appropriation is allocated to affiliated hospitals based on their proportion of indigent care losses, and half of the appropriation is allocated to the full-time and part-time EVMA physicians, based on the units' proportion of indigent care losses.

In fiscal year 1983, the appropriation of \$3.3 million for indigent care was applied to the care of 384 inpatient cases and 6,941 outpatient cases.



# WASHINGTON

## I. STATE INDIGENT CARE PROGRAMS

The state of Washington has two indigent care programs: the medical services component of the General Assistance-Unemployable program and the Limited Casualty-Medically Indigent program.

### A. General Assistance - Unemployable

The General Assistance-Unemployable (GA-U) program is a uniform state program that provides cash assistance and medical services to adults who have an emotional, physical, or mental impairment that precludes employment. Such individuals must be incapacitated for at least 2 months before they are eligible.

#### 1) Eligibility Standards

##### a) Categorical

Categorical recipients of General Assistance - Unemployed are automatically eligible for medical care.

##### b) Income

Not available.

##### c) Assets

Not available.

## 2) Services and Providers

### a) Services Covered

The GA-U program provides virtually the same services as the Washington Medicaid program. Services not covered under GA-U include dental services and Early Periodic Screening Detection and Treatment (EPSDT) for children.

### b) Providers and Settings

The GA-U program reimburses the same providers as the Title XIX Medicaid program, with the exception of dentists.

## 3) Administration

### a) Responsible Entities

The state establishes eligibility standards, conducts the eligibility determinations and processes providers' claims.

### b) Funding Source

The state provides 100% of the program funding.

### c) Reimbursement Methodology

Inpatient and outpatient payments are based on a prospectively determined percent-of-charge ratio; long-term care facilities are reimbursed on a prospective rate for individual facilities; and physicians are reimbursed on a fee-for-service system based on relative value.



## 4) Recipient and Expenditure Data

a) Total Expenditures

## GA-U Medical Expenditures

Service	FY 80	FY 81	FY 82	FY 83
IP hospital	\$ 5.86	\$ 9.90	\$20.45	\$25.61
Physicians	2.97	3.73	4.86	5.74
OP hospital	0.93	1.54	2.14	2.91
Drugs	0.87	0.98	1.02	1.37
Dental	1.16	0.95	0.16	0.24
Other	0.91	0.88	1.10	1.35
Total	\$12.74	\$18.00	\$29.77	\$37.25

(in millions)

b) Recipients Served

## GA-U Medical Recipients\*

Program	FY 81	FY 82	FY 83
GA-U	5,421	5,754	7,248

\* Duplicated, monthly count

A 1982 review of the GA-U program found that program recipients were predominantly single adults, that 58% were male, and that the average age was 37.

## 5) Recent and Proposed Changes

Major changes in the medical component of the GA-U program include the following:

- 2/2/82
1. Prescription drugs limited to specific therapeutic classification (see 2/1/84 entry);
  2. Prior approval required for all elective hospital admissions and surgery;
  3. Mental health services available only in mental health centers; and
  4. Hearing aid services dropped.

- 7/1/83 Seven-day retroactive period for medical care services eliminated.
- 8/23/83 Program expanded to include medical coverage for certain pregnant women not eligible for AFDC.
- 2/1/84 Prescription drugs restored to full formulary and added coverage of hearing aids.

B. Limited Casualty Program - Medically Indigent

Washington's second indigent care program is the medically indigent component of the Limited Casualty program. (The other major component of LCP is the medically needy component of the Title XIX Medicaid program.)

The LCP-MI program covers medical care for certain persons who are not eligible for any other programs. Similar to the medically needy program under Title XIX, indigents must spend down any excess income or resources and pay a deductible of \$500 per year. Treatment is limited to acute and emergency conditions.

1) Eligibility Standards

a) Categorical

Applicants may not be eligible for other state or federal programs.

b) Income

Follows the federal/state SSI standards

c) Assets

Liquid and nonliquid assets cannot exceed \$2,250 for a family of 2. Any excess must be spent down before the applicant is eligible. Vehicles with equity values of less than \$1,500 are excluded.

d) Other

The medical condition must be verified as acute and an emergency, or as a pregnancy. Eligibility may not exceed 3 months.

## 2) Services and Providers

a) Services Covered

The LCP-MI program covers inpatient hospital services, outpatient hospital services, physicians' services, drugs, ambulance services, x-rays and tests, some long-term care services, and other services.

b) Providers and Settings

All providers must be licensed Title XIX Medicaid providers.

## 3) Administration

a) Responsible Entities

The state establishes the eligibility criteria, conducts the eligibility determinations and processes providers' claims.

b) Funding Source

The LCP program is 100% state funded.

c) Reimbursement Methodology

Inpatient and outpatient hospital services are prospectively determined as a percentage of charge. Physicians are paid on a fee-for-service based on relative value. Long-term care facilities are prospectively paid, with each facility having its own rate.

## 4) Recipient and Expenditure Data

a) Total Expenditures

## LCP-Medically Indigent Expenditures

Services	FY 80	FY 81	FY 82	FY 83
IP hospital	\$ 8.62	\$ 6.24	\$11.17	\$12.14
Physician	2.09	1.38	1.32	1.11
OP hospital	0.24	0.21	0.24	0.17
Dental	0.04	0.36	0.00	0.00
Drugs	0.02	0.01	0.04	0.03
Other	0.17	0.15	0.08	0.07
Total	\$11.20	\$ 8.37	\$12.88	\$13.55

(in millions)

b) Recipients Served

## LCP-Medically Indigent Recipients\*

Program	FY 80	FY 81	FY 82	FY 83
LCP-MI	966	613	547	723

\* Duplicated average monthly count

A review of the LCP-MI recipients of January 1983 found that 58% were females, 30% were a single-member family, 11% were part of a 2-member family, 59% were from families with 3 or more members, 30% were under the age of 18, 11% were ages 18-20, 43% were ages 21-35, and 16% were ages 36 or above. Twenty-eight percent of the recipients had no family income, 32% had monthly incomes of \$500 or less, 26% had monthly incomes between \$501 and \$1,000, and 8% had monthly incomes over \$1,000. The incomes of 6% of the recipients were unknown.

## 5) Recent and Proposed Changes

The deductible (currently \$500) has changed five times since November 1980, ranging from a low of \$200 to a high of \$1,500. In March 1981, dental and podiatry services were eliminated. In July 1981, podiatry and denture services were restored.



### III. INDIGENT CARE PROVISIONS UNDER RATE SETTING

The Washington legislature enacted S.B. 4403 (Chapter 288) during its 1984 session. The bill's intent is to strengthen the authority of the hospital commission to contain hospital costs and promote competition among health care delivery systems.

The bill increases the commission's authority and responsibility in several areas. It authorizes the commission to collect and maintain discharge data, including data necessary for identification of discharges by DRGS. It also requires hospitals to file their annual proposed budgets, including revenues, expenses, and any other information the commission requires. The commission has discretionary authority to develop an all-payer, prospective reimbursement system, but the bill requires that any prospective reimbursement system developed by the commission deal equitably with the costs of providing charity care.



# WEST VIRGINIA

## I. STATE INDIGENT CARE PROGRAMS

West Virginia does not have a state or state-county indigent care program. County general assistance programs may reimburse providers for medical care, but the benefits and eligibility criteria vary by county.

## III. INDIGENT CARE PROVISIONS UNDER RATE SETTING

The West Virginia legislature enacted a bill in 1983 that authorizes an all-payer prospective rate setting system. The bill is silent regarding the way uncompensated care is to be treated under the new system. Medicaid rates must be "...reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated hospitals." The rates must take into account the situation of hospitals that serve disproportionate numbers of low income-patients and ensure that Medicaid recipients have reasonable access to adequate quality inpatient services, taking location and travel time into account.

West Virginia officials are in the process of designing and implementing the new reimbursement system. The state proposes to base it on DRGs and is slated to take effect during 1985. They are planning to submit a waiver permitting Medicare's participation. State officials plan to include charity care and bad debts as reimbursable expenses, but no definition of those terms or reimbursement methodology has yet been developed. Allowances for uncompensated care, however are not planned to be sufficient to cover all the costs hospitals incur in providing such care.

A West Virginia task force is charged to devise some strategy in addition to rate setting, to alleviate the state's problem with uncompensated care, which is particularly severe for at least two reasons. A large proportion of West Virginia's population consists of poor and near-poor people who have been

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particularly hard hit by the 1981-82 recession, and the state's industrial base is such that the recession's effects are likely to linger longer in West Virginia than in other parts of the country.

In addition, very stringent Medicaid reimbursement policies have exacerbated the magnitude of the problem. The state reduced the number of covered inpatient days from 60 to 20 and eliminated all emergency room coverage except for "truly emergent" conditions. In addition, Medicaid has historically paid for outpatient services on a fee-for-service basis, which amounts to approximately 40% of charges and payments to hospitals considerably below their costs. As a result of all these factors, West Virginia's costs for uncompensated are around \$75 million annually.



# WISCONSIN

## I. STATE INDIGENT CARE PROGRAMS

### A. General Relief-Medical

Effective July 1, 1983, the state of Wisconsin began reimbursing counties and municipalities for a certain percentage of General Relief medical claims (the state also provides some financial support for the nonmedical components of General Relief). One of the reasons for the state's involvement was a doubling of General Relief expenditures (all locally funded) during the period from 1980 to 1981.

#### 1) Eligibility Standards

##### a) Categorical

General Relief recipients are automatically eligible for medical services in most jurisdictions. Because the eligibility standards are established by the local jurisdictions, however, there may be exceptions. In 1984, there were 624 administering jurisdictions: 51 counties and 573 units (city, towns, and villages) within the other counties.

All other standards of eligibility vary by county.

#### 2) Services and Providers

The local jurisdiction decides which services to cover and which providers to reimburse. Many counties use the medically needy component of the Title XIX Medicaid program as a guide for deciding which services to cover. Nonemergency care must be prior authorized by the local jurisdiction.

### 3) Administration

#### a) Responsible Entities

The local jurisdiction establishes the eligibility criteria, conducts the eligibility determinations and processes providers' claims.

#### b) Funding Source

Before July 1983, no state funding was available for the General Relief program. Currently, the state reimburses local jurisdictions 10% of the portion of individual GR medical claims between \$500 and \$5,000, and 50% of the portion of the claims over \$5,000. The local jurisdiction is responsible for all costs. To receive state funds, the local jurisdiction must:

- Prior authorize nonemergency medical care;
- Develop a medical cost containment plan that, in part, limits inappropriate emergency room use and/or provides for case management; and
- Use the state-developed form when submitting claims.

### 4) Recipient and Expenditure Data

For state fiscal year 1983, the state spent \$1.3 million (which represents 6 months of expenditures). For state fiscal year 1984, the first full year of state fundings, the state spent \$4.8 million.

### 5) Recent and Proposed Changes

The governor has recommended further changes in the locally administered General Relief program. The two key recommendations affecting the medical component of GR include a phased-in increase for state funding of the portion of medical claims over \$10,000 and incentives to convert the unorganized GR units (those counties with city, town, and village programs) into countywide programs.

## II. LIMITED STATE INDIGENT CARE PROGRAMS

### A. Chronic Renal Disease Program

Wisconsin funds a program for residents who have been diagnosed as suffering from chronic renal disease and are in need of either dialysis or a transplant to survive. The program covers pharmacy, physician, hospital and home dialysis supply costs. Reimbursement for Medicare covered services is at Medicare's rate; while reimbursement for Medicaid services is at Medicaid's rate.

The program has no income eligibility requirements, but recipients are required to pay deductibles and copayments. Yearly deductibles are \$75.00 for outpatient services and \$356.00 for inpatient services. Copayments levels are based on recipients' incomes and family sizes and range from 0% to 15%. If recipients are receiving other types of assistance (i.e. Medicare or Medicaid) or have private health insurance, then the program acts as the payer of last resort.

The program was appropriated \$1.7 million for FY 1985, and currently has approximately 2,000 living recipients. There are approximately 30-35 new recipients each month.

### B. Hemophilia Program

Wisconsin covers home blood products and supplies for persons who have been diagnosed as having hemophilia. Residents whose incomes do not exceed \$750,000 are eligible to participate, with their financial liability for care determined by income and family size. Recipient's liability for care ranges from 0% to 15%. The program was appropriated \$140,000 in FY 1984 and served a total of 101 persons.

### C. Needy Indians Program

Wisconsin has a totally state funded program for needy Native Americans who are state residents. Income eligibility criteria are similar to the states' Aid to Families with Dependent Children's Program (AFDC); the program provides both cash assistance and medical coverage identical to Medicaid's coverage. The state has contracted with ten Indian tribes for program administration. In FY 1983, expenditures were \$1.8 million for medical care.



### III. INDIGENT CARE PROVISIONS UNDER RATE SETTING

Wisconsin replaced its voluntary rate setting program with a mandatory program one for Blue Cross and charge based payers for hospital fiscal years beginning after February 1, 1985. The hospital commission reviews each hospital's budget to determine its total financial requirements. After that, payments from Medicare, Medicaid, and General Relief subtracted out, and the commission will set charges sufficient to meet each hospital's financial requirements. Hospitals are permitted to adjust rates selectively within hospitals as long as their total revenue does not exceed budgeted revenue.

Included in the determination of financial requirements are contracted allowances for shortfalls from Medicare, Medicaid, and general relief as well as allowances for charity care and bad debts. Charity care is defined as "the reduction in hospital charges for patient care services due to indigency of the patient." Allowances for charity care are subject to a test of reasonableness and do not include bad debts or contractual allowances for Medicare, Medicaid, or general relief. Bad debts are defined to exclude charity care and public-sector contractual allowances and are also subject to a test of reasonableness. Hospitals must make an effort to collect charges before charges can be claimed as bad debts.

### IV. HEALTH INSURANCE ALTERNATIVES

#### A. Comprehensive Health Insurance and Risk Pool

In May 1980, Wisconsin enacted a statute that requires most health insurers, health maintenance organizations, and self-insurers in the state to participate in an insurance risk-sharing pool. The pool is designed to provide eligible individuals an opportunity to purchase comprehensive health insurance. Everyone, except those specifically excluded by law, may participate in the program. Those not eligible to participate include persons eligible for Medicaid, persons who had been participating in the risk pool but who voluntarily terminated their coverage less than 12 months previously, persons who have already received at least \$250,000 in benefits from the plan and persons aged 65 or older.

Wisconsin's risk pool is modeled after Minnesota's. All



insurers must share in the pool's operating and administrative costs. Insurers' assessments are determined annually by comparing their proportional premium income to premiums generated by all health insurers in the state in the previous year. Insurers are required to notify people of the availability of the pool, eligibility requirements, and application procedures under specified conditions concerning rejection or limitation of coverage and large increases in premiums.

#### 1) Covered Services

The risk pool provides coverage for the following services, with reimbursement based on usual, customary or reasonable (UCR) principles:

- Hospital services;
- Basic medical/surgical coverage (including chiropractic coverage), including inpatient and outpatient hospital medical and surgical care, diagnoses, anesthesia consultation, and in-hospital outpatient services for alcoholism, drug abuse, and mental and nervous disorders provided by a physician or under the supervision or direction of or on referral from a physician;
- Drugs requiring a physician's prescription;
- Services of a licensed skilled nursing facility for persons eligible for Medicare, for not more than 120 days during a policy year, if the services are reimbursable by Medicare;
- Use of radium or other radioactive materials;
- Oxygen;
- Anesthetics;
- Prostheses other than dental;
- Rental or purchase of durable medical equipment, except eye-glasses and hearing aids;
- Diagnostic x-rays and lab tests;
- Oral surgery for partially or completely unerupted, impacted teeth and oral surgery with respect to tissues of the mouth when not performed in connection with the extraction or repair of teeth;
- Services of a physical therapist;
- Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;
- Some services of a licensed skilled nursing facility;
- Health insurance coverage required under some other state laws; and
- Processing charges for blood, including, but not limited to, the cost of collecting, testing, fractionating, and distributing blood.

Covered services do not include:

- Cosmetic surgery for purposes other than the repair or

- treatment of an injury or a congenital body defect;
- Care that is primarily custodial or domiciliary and does not qualify as an eligible service under Medicare;
  - Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a physician prescribes a private room as medically necessary;
  - That part of any charge for services or articles rendered or prescribed by a physician, dentist, or other health care personnel that exceeds the prevailing charge in the locality where the service is provided, or any charge not medically necessary;
  - Any charge for services or articles, the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles;
  - Any expense incurred before the effective date of coverage under the plan for the person on whose behalf the expense is incurred;
  - Some dental care;
  - Eyeglasses and hearing aids;
  - Routine physical examinations, including those to determine the need for eyeglasses and hearing aids;
  - Illness or injury due to acts of war; and
  - Services of blood donors and any fee for failure to replace the first 3 pints of blood provided to an eligible person during a policy year.

The plan has an annual deductible of \$1,000 and a lifetime limit of \$250,000 per covered individual for those with major medical expense coverage. Covered costs in excess of the major medical deductible are reimbursed at 80% and at 100% of all covered costs after certain payment ceilings are exceeded. This situation occurs when the total annual expense (the deductible and covered costs not paid by the plan) exceed \$1,500 for individuals and \$5,000 for all eligible persons in a family. A preexisting condition clause prohibits payment for conditions that had been diagnosed or treated in a 6-month period immediately preceding filing application with the plan. The pool is the payer of last resort; coverage is provided only when other sources of payment have been exhausted.

## 2) Experience

When the risk pool was enacted into law in 1980, it was designed to be financially self-sufficient within 3 years. After that point, the plan was to be prohibited from charging premiums in excess of 130% of the rates that would be charged to individuals for comparable coverage. However, that provision has since been modified; premiums may now be in excess of 150% of the rates charged to persons of standard risk. The expectation that the plan would become financially self-sufficient has not been met, and it is no longer thought to be realistic. Premiums now range from \$600 to \$1,836 per

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year, depending upon age, sex, and location of residents.

Data from a 1984 survey of subscribers (46.2% of all subscribers responded) revealed:

- 75% of respondents were aged 40 or older;
- 50% had household incomes under \$12,000 a year;
- 71% had no children living with them;
- 61% were unemployed;
- 58% rated their health as good or excellent;
- 97% were eligible to participate in the plan because they had been rejected by two or more insurers;
- 53% felt the deductibles were too high.





# WYOMING

## I. STATE INDIGENT CARE PROGRAMS

### A. Minimum Medical Program

Wyoming's Minimum Medical Program (MMP) provides state funds to counties for medical expenses provided under the county General Assistance program.

#### 1) Eligibility Standards

##### a) Categorical

Recipients of SSI, AFDC-FC, and licensed sheltered care are automatically eligible.

##### b) Income

Individual .....	\$540/month
Family of 4 .....	\$1,105/month

##### c) Assets

Excluded from the definition of assets are \$1,000 in savings and the auto up to \$1,5000 in equity value.

##### d) Other

Each county -- at its option and provided sufficient funds are available -- may extend services to individuals or families with sufficient income to meet maintenance needs, but not to meet medical needs.

## 2) Services and Providers

### a) Services Covered

Services covered are the same as those covered by the categorically needy component of the Title XIX Medicaid program, plus prescription drugs (which are not covered under the Title XIX program). Counties have the option of establishing different limits on the amount or duration of services.

## 3) Administration

### a) Responsible Entities

The state establishes the eligibility standards, conducts the eligibility determinations and processes providers' claims.

### b) Funding Source

The Minimum Medical Program is 100% state funded.

### c) Reimbursement Methodology

Not available.

## 4) Recipient and Expenditure Data

### a) Total Expenditures

In the 1983-1984 biennium, the state appropriated \$4.2 million.

### b) Recipients Served

Not available.







## APPENDIX A

### CONTINUATION and CONVERSION POLICIES

Continuation and conversion of group health insurance benefits are strategies for dealing with two different problems. Continuation allows insured individuals to maintain a current health insurance policy for a limited period of time; it is most effectively used when the loss of group eligibility is expected to be transient (i.e., job termination, layoffs and labor disputes). Conversion policies are issued to terminated group members on an individual basis; it is expected that these policies will be in effect for some time (i.e., job termination, divorce or death of a covered spouse).

Thirty one states have statutes that mandate insurers to offer policyholders, who purchased their policy at their place of employment, the option to purchase insurance policies with similar coverage. If the group policy covers basic hospital or surgical expense insurance, the insurer must offer similar benefits. It is important to note that specific coverage varies with each state's statute.

Many states have adopted legislation that conforms to the model conversion law issued by the National Association of Insurance Commissioners. Under these model provisions, an insurer is not mandated to issue a converted policy if the person is: eligible for Medicare; covered for similar benefits under another policy; or eligible for similar benefits under another group policy.

For the most part, state continuation legislation includes the following provisions:

- Individuals have 31 days to exercise their continuation option;
- Only persons continuously covered by a group policy for the three months immediately preceding coverage termination are eligible for this privilege;
- Continuation is not required if the individual is eligible for or covered by another policy (Medicare, private health insurance or a similar federal or state program); and
- The persons electing to continue coverage pay at the former group rate, but must also pay the employer's share of the premium.

The table follows on the next page:

CONTINUATION AND COVERSION POLICIES  
(Spring, 1985)

Continuations			Conversion	
Termination	Layoff	Time Limit	Termination	Layoff
AR X	X	120 days	X	
CA			X <sup>1</sup>	X <sup>1</sup>
CO				
CT X	X	39 weeks	X <sup>1</sup>	X <sup>1</sup>
FL				
IL			X <sup>1</sup>	X <sup>1</sup>
IA			X	X
KS X	X	6 months	X	X
KY X	X	9 months	X	X
ME			X	X
MD			X <sup>1</sup>	X <sup>1</sup>
MA	X <sup>2</sup>	39 weeks		
MN X <sup>1</sup>	X <sup>1</sup>	12 months	X <sup>1</sup>	X <sup>1</sup>
MO			X	X
MT X <sup>1</sup>	X <sup>1</sup>	1 year	X <sup>1</sup>	X <sup>1</sup>
NE X	X	6 months		
NV			X	X
NH X	X	39 weeks	X	X
NM X <sup>1</sup>	X <sup>1</sup>	6 months	X <sup>1</sup>	X <sup>1</sup>
NY			X	X
NC X	X	3 months	X	X
OH X		6 months	X	
OK X <sup>1</sup>	X <sup>1</sup>	30 days	X	X
OR X <sup>1</sup>	X <sup>1</sup>	6 months	X	X
PA			X <sup>1</sup>	X <sup>1</sup>
RI	X	10 months	X	
SC X <sup>1</sup>	X <sup>1</sup>	1 month <sup>3</sup>	X <sup>1</sup>	X <sup>1</sup>
SD X		3 months	X	
TN X	X	3 months	X	X
UT			X <sup>1,4</sup>	X <sup>1,4</sup>
VA X		90 days	X	
WA X	X	6 months	X <sup>1,4</sup>	X <sup>1,4</sup>
WV	X <sup>2</sup>	18 months	X <sup>1</sup>	X <sup>1</sup>
WI X	X	12 months	X	X
WY			X <sup>4</sup>	X <sup>4</sup>

19 states with continuation statutes  
31 states with conversion statutes

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Notes

- 1 Includes Blues and HMOs
- 2 Involuntary
- 3 Plus remainder of current month
- 4 Includes prepaid plans

- Louisiana - Continuation for surviving spouses fifty years of age or older for deceased employees covered under group, blanket or franchise policies.
- Maryland - Continuation for dependent children under a parent's group contract if the children were previously under the deceased parent's contract.
- New Jersey - Continuation for family members for 180 days upon death of covered spouse; conversion for former spouse losing coverage as a result of divorce.
- Rhode Island - Continuation for divorced persons if order for continuation is specified in divorce agreement. Continuation to be in effect until either party remarries or until date specified in divorce decree. Applies to self insured plans.
- South Dakota - Conversion for spouse losing coverage as a result of divorce, death of subscribing spouse, and to children of a deceased subscriber.
- Texas - Continuation for totally disabled workers for the period of total disability or 90 days, whichever is less; also, any insurance policy entered into as a result of a collective bargaining agreement must have a continuation provision.
- Vermont - Continuation for persons whose coverage would terminate due to the death of the covered member.

Total including these is 42 states.





APPENDIX B

MEDICAID SERVICES, STATE BY STATE

### Basic Required Medicaid Services

Services provided only under the Medicare buy-in or the screening and treatment program for individuals under 21 are not shown on this chart

● CN? + Both CN and MN? BASIC REQUIRED MEDICAID SERVICES FMAP: SEE ABOVE	Podiatrists' Services																Optometrists' Services																Chiropractors' Services																Other Practitioners' Services																Private Duty Nursing																Clinic Services																Dental Services																Physical Therapy																Occupational Therapy																Speech, Hearing, and Language Disorder																Prescribed Drugs																Dentures																Prosthetic Devices																Eyeglasses																Diagnostic Services																Screening Services																Preventive Services																Rehabilitative Services																Services for Age 65 or Older in TB Institutions				Services for Age 65 or Older in Mental Inst				Intermediate Care Facility Services																ICF for Mentally Retarded																Inpatient Psychiatric Service for Under Age 22																Christian Science Nurses																Christian Science Sanitorie																SNF for Under Age 21																Emergency Hospital Services																Personel Care Services																Total Additional Services																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																
	71	50	61	74	50	50	50	50	50	56	67	50	55	51	71	64	50	50	50	53	78	61	64	57	50	59	50	69	50	51	68	50	55	58	57	56	50	58	71	69	71	54	68	69	50	57	50	71	52	50	34	54	40	46	29	33	18	39	42	36	27	33	52	33	20	29	48	42	23	17	20	29	19	12	33	24	36	42	24	23	17	20	29	19	8	1	7	8	1	15	9	17	30	24	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6	5	18	46	42	19	5	14	19	42	18	20	26	23	49	20	33	6

(Federal Medicaid Assistance Percentage(FMAP) Rate of Federal financial participation in a State's Medical Assistance Program under Title XIX of the Social Security Act. Percentages are rounded and effective as of October 1, 1983)

**2. Categorically Needy** People receiving federally supported financial assistance

### 3 Medically Needy People who are eligible for medical but not for financial assistance

\*Arizona operates a medical assistance program under e Section 1115 Demonstration project

**Reference:** The data shown were reported by individual states and compiled by the Office of Intergovernmental Affairs

## **Intergovernmental Health Policy Project**

### **George Washington University**

The Intergovernmental Health Policy Project serves a unique function in the development of the nation's health policy. It is the only university-based program in the country concentrating its research efforts exclusively on the health laws and programs of the 50 states. The Project provides assistance to state executive officials, legislators, legislative staff and others who need to know about important developments in other states. At the same time, the IHPP helps federal officials identify innovative state health programs and specific state problems.

To facilitate these information-brokering activities, the IHPP maintains direct links with state governmental agencies, state legislatures, research centers, planning agencies, and interest groups throughout the country. Reliable, up-to-date information on health legislation and programs is obtained through IHPP's own network of knowledgeable health policy experts in each of the 50 states, as well as from its clearinghouse of all state health legislation.

Through its newsletter, *State Health Notes*, research publications, and conferences, the IHPP provides key health policymakers with timely, comprehensive examinations of innovative state legislative activities and health programs.

The Intergovernmental Health Policy Project is affiliated with the National Health Policy Forum, with which it works closely to identify issues of concern to state and federal policymakers. The National Health Policy Forum is a privately funded non-profit organization which provides in-service educational experiences to high level congressional, White House and executive agency specialists in health care. Both the IHPP and the NHPF operate under the auspices of the George Washington University in Washington, D.C.

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